

DOCTORAL THESIS

The assessment and treatment of intellectually disabled sexual offenders; the development and evaluation of the Becoming New Me treatment programme

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***The assessment and treatment of intellectually disabled sexual offenders; the
development and evaluation of the Becoming New Me treatment programme.***

By

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Abstract

Approximately 30% of offenders are intellectually disabled, yet little is known about effective treatment with this group. The aim of this thesis is to advance our understanding of intellectually disabled sexual offenders (IDSOs) through the development and evaluation of a treatment programme, Becoming New Me (BNM). The Risk, Need and Responsivity (RNR) model (Andrews *et al.*, 1990) is the only empirically validated model of offender rehabilitation. Meta analytic studies have shown that the RNR principles apply to various offender populations, including sexual offenders, but no work has looked at their relevance to IDSOs. As such, the research question in this thesis is; can the RNR model be successfully applied to the treatment of IDSOs? The literature pertaining to each principle and its applicability to IDSOs is reviewed and the development of the BNM in line with the findings is described. In order to evaluate the success of the BNM approach, and thereby assess the utility of the RNR model, an outcome and a process evaluation were undertaken. The research involved 131 BNM programme completers and focus group discussions with 19 BNM participants and 20 therapists. In order to assess criminogenic needs, eight assessment measures were developed and found to have acceptable psychometric properties. Change was observed in the hypothesised direction on most of the measures irrespective of risk, IQ, age or offence type. Where change in the desired direction was not found, explanations are offered. The results of the process evaluation reveal that the treatment experience for BNM participants and therapists was generally positive. Further, this research provides new insights into the factors which are relevant to responsivity in the treatment of IDSOs. It is concluded that the RNR model is applicable to the treatment of IDSOs. Possible recommendations for practice and further research are identified but limitations are recognised.

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Chapter 1: Introduction

The aim of this thesis is to advance our understanding of the assessment and treatment of intellectually disabled sexual offenders (IDSOs). Although sex offender treatment in general has received a lot of research attention over the last 20 years, relatively little is known about the assessment and treatment of this specific client group. Yet, IDSOs are likely to constitute approximately 30% of the offender population (Mottram, 2007) and as such, it is important that our understanding of this client group is improved. As a first step towards fulfilling the research aim, the literature pertaining to effective treatment approaches with this client group will be outlined in this chapter. More specifically, a model of offender rehabilitation, the Risk Needs Responsivity (RNR) model (Andrews, Bonta, and Hoge, 1990) will be described. Although the applicability of this model to various specific client groups has been determined (see Dowden and Andrews, 2000; Di Placido, Simon, Witte, Gu, and Wong, 2006; Hanson, Bourgon, Helmus, and Hodgson, 2009), there has been no research to support the use of the RNR model with IDSOs. As such, the research question in this thesis is; can the RNR model be successfully applied to the treatment of IDSOs? The chapter also includes a review of various methods of evaluation, and the chapter closes with a short overview of the thesis.

1.1 Sexual offending: a societal problem

Sexual offences are seen by the public to be among the most disturbing of crimes, and there is considerable concern about the risk posed by sexual offenders in the community (Hanson, 2006). The fight against sex offending is high on the UK government's agenda as they argue sexual crime, and the fear of sexual crime, has a profound and damaging effect on the social fabric of communities (Home Office, 2002). The human and financial cost of sexual offending to victims and the social and health services is high, as is the public investment in policing, prosecuting, and incarcerating offenders. Sexual offending has thus, become a major challenge for social policy.

1.2 Intellectual disability and sex crime

Some sex crimes are undoubtedly committed by those who are intellectually disabled, but the exact proportion compared to those committed by the non ID population, is unclear. One of the possible reasons for this lack of clarity lies in the variety of terms used to describe those whose functioning is less than “average.” In the UK, the term “learning disability” has replaced the original term of “mental retardation” (although this is still an accepted term in the USA). Other terms used (especially in the USA and Australia) include “developmental disability,” “mental impairment,” “intellectual dysfunction,” and “special needs.” The term “learning difficulty” is also used to describe features of this group, usually specific learning difficulties, e.g. Dyslexia. The huge range of terms to describe this client group has resulted in confusion in the literature.

The UK Department of Health use three criteria to define “Learning Disability” in their White paper “Valuing People” (2001). These are;

- A significantly reduced capacity to understand complex information or learn new skills (impaired intelligence)
- A reduced ability to cope independently (impaired adaptive functioning)
- A condition which started before adulthood (18 years of age) and has a lasting effect.

This definition is broadly consistent with that used in the current version of the World Health Organization’s International Classification of Disease (ICD-10). In diagnosis, all 3 factors are considered. The first, impaired intelligence, is relatively straight forward and is routinely assessed using the Weschler Adult Intelligence Scales (Kaufman and Lichtenberger, 1999). The British Psychological Society identifies Learning disability as IQ < 70 (British Psychological Society, 2001). An individual who has been diagnosed as being learning disabled will be categorised with regards to severity. There are five categories.

Borderline IQ level 70 – 80

Mild	IQ level 50 – 55 to 70
Moderate	IQ level 35 – 40 to 50 – 55
Severe	IQ level 20 – 25 to 35 – 40
Profound	IQ level below 20 – 25

However, the second criterion adaptive functioning is much more difficult to assess. Numerous measures are available, but psychometric difficulties and other shortcomings mean that there is no “gold standard” tool recommended to assess adaptive functioning (BPS, 2001). As a result, intellectual functioning is often used as the determining criterion for assessment. The assumption made is that once a cognitive impairment has been established, similar deficits in social and adaptive skills are likely. Nevertheless, it is a mistake to overemphasise the role of IQ as an indicator of appropriate treatment strategies as IQ does not solely determine ability (Coleman and Haaven, 2001). The third criterion, suggests that the learning disability must be a long lasting condition which started prior to the age of 18. This aspect of the learning disability classification can be determined via interview with the individual and supportive file evidence.

It is unlikely that individuals with moderate, severe or profound learning disabilities will be in Prison or on Probation caseloads (Holland, Clare, and Mukhopadhyay, 2002; Talbot, 2007). Individuals with more severe learning disabilities are usually transferred into the National Health Service. Consequently, the majority of learning disabled offenders in custody and in the community, are likely to be assessed as having mild or borderline disabilities, that is, they are likely to have an IQ of 80 and below. As this group are not strictly speaking “learning disabled” (according to the BPS criteria), they are described within the National Offender Management Service (NOMS)¹ as “intellectually disabled.”

¹ The National Offender Management Service (NOMS) is an executive agency of the Ministry of Justice, bringing together the headquarters of the Probation Service and HM Prison Service to enable more effective delivery of services.

Although, It is unclear what exact proportion of sex crimes are committed by those who are intellectually disabled, they do constitute a significant proportion of the total offender population. Mottram (2007), in a study of 3 prisons in England reported that around 30% of the prison population have IQs of under 80. But the proportion of IDs in the total sex offender population is unclear.

Recent research on sexual offender populations has suggested that men with ID may be more prevalent than previously thought (Timms and Goreczny, 2002). Lund (1990), Gross (1985), Walker and McCabe (1973), Day (1994) and Hodgins (1992) have all noted such a relatively high incidence of sexual offending amongst ID populations. Cantor, Blanchard, Robichaud and Christensen (2005) conducted a meta analysis of reports on sexual offending and IQ which included over 25,000 sexual offenders and controls. A significant relationship between low IQ and sexual offending, particularly paedophilia was found.

However, Ho (1997) in a study on 228 individuals which included 82 sexual offenders from the 'Mentally Retarded Defendant Programme' in Florida, a secure institution for offenders who are not considered competent to stand trial because of their ID, found that there were no significant differences between sexual offenders and other retarded offenders. Hayes (1991) similarly reported that there was no clear evidence for either over representation or under representation of ID in the sexual offender population.

Another relevant issue is whether the actual offences committed by the ID group differ in their seriousness from the offences committed by the non ID group. Again, the evidence is mixed. On the one hand, Hodgins (1992) for example, suggested that ID offenders were five times more likely to commit a violent offence (including rape and molestation) than non ID offenders. In contrast, Courtney and Rose (2004) found that offences committed by ID sexual offenders were more likely to be sexual touching than attempted or actual penetration. In terms of their offending behaviour,

the researchers found that ID sexual offenders were more likely to choose adult male stranger victims, be opportunistic, exhibit less violence, and not use alcohol at the time of the offence than non ID sexual offenders. However, Gilbey, Wolf, and Goldberg (1989), Day (1994), and Lindsay, Smith, Law, Quinn, Anderson, Smith, Overend, and Allan (2002) reported that ID sexual offenders frequently show other challenging behaviours, such as aggression, and that they may have other non sexual convictions. Researchers have generally concluded that in the absence of any population studies, the types of offences committed by individuals with ID seem to be similar to those of individuals without ID (Jones, 2007).

A further possible cause for concern is the sexual recidivism rate for ID sexual offenders. The data are again unclear. Klimecki *et al.*, (1994) reported a re offending rate of 41.3% in prison inmates with ID at a 2 year follow up, and a 34% recidivism rate for non ID sexual offenders. Craig *et al.*, (2005) reported that the re offence rates for ID sex offenders ranged from 2% to 12% in a 4 year follow up, from 3% to 14% in a 6 year follow up, and from 18% to 25% in a 21 year follow up (Craig, Browne, Hogue and Stringer, 2005). These rates are high compared to non IDSOs. Indeed, Craig and Hutchinson (2005) calculated that the reconviction rate for ID sexual offenders is 6.8 times and 3.5 times that of non ID sexual offenders at the 2 and 4 year follow ups respectively. Craig and Hutchinson calculated this based on Klimecki *et al.*,’s (1994) and Lindsay *et al.*,’s (2002) re offending rates. However, the authors go on to point out that methodological problems and inconsistencies between the studies mean that caution should be taken when interpreting these results. The most that can be concluded is perhaps that the incidence of sexual offending and sexual recidivism is at least as high as in non- ID offenders.

In summary, sexual offending is an important problem in British society. Offenders with ID constitute approximately 30% of the prison and probation population. Although no clear data are available for the proportion of sex offenders who are intellectually disabled the literature suggests that, individuals with IDs are as likely, or indeed as some findings suggest, more likely to commit

sexual offences than their non ID counterparts. It is important, therefore, that treatment options for ID offenders are developed and evaluated.

In 1996, HM Prison Service responded to this need and developed a treatment approach for low IQ men who had committed sexual offences. This was known as the Adapted Sex Offender Treatment Programme (ASOTP) and was accredited for use in prisons in 1997 (for further details about accreditation please see chapter 5.7). The ASOTP ran in the Prison service from 1997 until 2009. An evaluation of the programme based on a group of 211 men who had completed treatment in custody is given in Williams, Wakeling and Webster (2007). Significant pre to post treatment change in the desired direction on a number of outcome measures was found. Yet in 2009 it was decided that a new programme for IDSOs was needed. There were a number of reasons for this decision. Firstly, the National Offender Management Service (NOMS) is committed to the delivery of “evidence-based” treatment approaches. Given that the ASOTP had been running for approximately 12 years, it was felt no longer to reflect the latest research findings. There was clearly a need to update and refresh various aspects of the delivery and treatment approach. Second, the programme was designed for and accredited for use within the prison system only. Due to organisational restructuring, a programme which was suitable for delivery in both custody and community sites had to be developed. This meant that a new programme was needed. In 2007 work began on the development of a new treatment approach for IDSOs. The first issue to be considered was the model of rehabilitation which would guide the treatment design.

1.3 Offender rehabilitation.

Historically, explanations of criminal behaviour have been dominated by sociological criminology, which located the cause of crime in the social structure, and was more interested in explaining aggregated crime rates than individual criminal behaviour (Andrews and Bonta, 1994). Andrews, Bonta, and Hoge (1990) urged practitioners, researchers and policy-makers to “rediscover” psychology in order to enhance correctional treatment effectiveness. Their psychology

is a social learning perspective that assumes that criminal behaviour is learned within a social context. Social support for the behaviour and cognitions conducive to criminal behaviour are central factors, as are criminal history and a constellation of antisocial personality factors (e.g., impulsiveness, thrill-seeking, egocentrism). Other factors of moderate relevance include family/marital functioning, substance abuse, and indicators of social achievement (e.g., education and employment). As a result, Andrews *et al.*, (1990) proposed that there were three principles at the core of effective rehabilitation: Risk, Need and Responsivity. The Risk-Need-Responsivity (RNR) model is perhaps the most influential model for the assessment and treatment of offenders (Ward, Mesler and Yates, 2007). It is certainly the most researched model to date. Yet, in more recent years various critiques of the model have been presented (e.g. Ward, 2002; Ward and Stewart, 2003a,b).

Ward and colleagues in essence argue that the RNR model focuses on risk management at the expense of other more psychologically relevant factors that come together to promote an individual's well-being and fulfilment. As an alternative model of rehabilitation, they offer the "good lives model" (GLM). The GLM model can be described as a strengths based model (as opposed to the RNR model which is risk based). Ward emphasises the importance of increasing the overall psychological well-being of offenders (beyond their criminogenic needs, Ward 2002). In defence of the RNR model, Bonta and Andrews (2003) argue that Ward's theoretical model lacks empirical support. Moreover, they argue that concepts underlying the GLM model also have not been tested with offender populations. The RNR protagonists have argued that the central tenants of the GLM can be assumed within a RNR approach. The two models do not have to be viewed as mutually exclusive.

Another movement in offender rehabilitation concerns the desistance from crime. Essentially, this model looks at how and why people desist or stop offending. Although the desistance model had been proposed at the time of the development of the BNM approach, the application to

treatment approaches was at the time of writing largely unknown. Indeed, despite a number of recent publications (e.g. Laws and Ward, 2010; McNeill, 2012; Ward and Maruna, 2007), the relevance of desistance to treatment remains poorly understood. Whilst it seems to be inherently plausible that treatment should target the factors that have led others to desist from crime, the process by which this can be achieved is still largely undefined.

In summary, although offender rehabilitation has been a societal concern for many years, the scientific study of criminal justice interventions has a relatively short history. The RNR model was proposed approximately 20 years ago. In more recent years, the GLM and the desistance model have been received favourably by those seeking to adopt more strengths based treatment approaches. Yet these newer models remain untested. The RNR remains the only empirically validated guide for offender interventions (Polaschek, 2012).

1.4 The RNR model

The RNR model is the only model of offender rehabilitation which has stemmed from and been supported by scientifically acceptable and robust meta analytical studies. The *risk* principle speaks to who should be treated. It states that the level of treatment services must be appropriately matched to the risk level of the offender. More specifically, higher risk offenders should receive more intensive and extensive services, whereas lower risk clients should receive minimal or no intervention. As Harkins and Beech (2007) noted, low risk offenders “are less likely to reoffend even without treatment” (p 616). Empirical support for the risk principle has been received from both primary and meta analytical studies (for a review see Dowden and Andrews, 1999).

The *need* principle describes what should be treated. The need principle makes a distinction between criminogenic and noncriminogenic needs. Offenders have many needs. Some are functionally related to criminal behaviour (i.e. criminogenic needs) and others have a very minor or no causal relationship to criminal behaviour (i.e., noncriminogenic needs). Table 1.1 presents some

examples of the major criminogenic and noncriminogenic needs. Criminogenic needs serve as the intermediate targets of change in rehabilitation process; when these needs are targeted in treatment and changed, reduced levels of criminal activity result (Andrews and Bonta, 1998; Andrews *et al.*, 1990).

Table 1.1

Criminogenic and Non criminogenic needs (reproduced from Andrews and Bonta, 2010; p46)

Criminogenic	Non criminogenic
Procriminal attitudes (thoughts, values and sentiments supportive of criminal behaviour)	Self-esteem
Antisocial personality (low self-control, hostility, adventurous pleasure seeking, disregard for others, callousness)	Vague feelings of emotional discomfort (anxiety, feeling blue and feelings of alienation)
Procriminal associates	Major mental disorder (schizophrenia, depression)
Social achievement (education, employment)	Lack of ambition
Family/marital (marital instability, poor parenting skills, criminality)	History of victimization
Substance abuse	Fear of official punishment
Leisure/recreation (lack of prosocial pursuits)	Lack of physical activity

Treatment targeting non criminogenic needs should not expect to reduce reoffending. Research has found that increasing the number of criminogenic needs targeted leads to a reduction in violent offending (Dowden and Andrews, 2000; Andrews and Bonta, 2006). In contrast, Andrews and Bonta (2006) have shown that targeting non criminogenic features actually reduces the beneficial effects of treatment. The correlations between addressing various non criminogenic needs and the overall effect size for treatment, ranged from $r = -.18$ to $r = -.20$. These are statistically significant negative influences.

The third principle, the *responsivity* principle, addresses the ‘how’ of intervention. It states that styles and modes of service used within treatment should be matched to the learning styles of the offender (Andrews and Bonta, 1998). Both general and specific responsivity considerations are

made. General responsivity states that the most effective types of approach for inducing positive behavioural change are based on cognitive behavioural and social learning approaches (Andrews *et al.*, 1990). Specific responsivity calls for the matching of treatment to client characteristics such as treatment readiness, various individual factors such as mental health, personality characteristics, and various demographic characteristics such as gender and age. Andrews and Dowden (2007) list the areas that should be considered for specific responsivity as; “gender-responsiveness, ethnic-responsiveness, age-appropriateness, clinical status, verbal intelligence, motivation, personality, and particular strengths upon which human service can build” (p447).

In summary therefore, the principles of RNR speak directly to the key questions in relation to effective treatment design.

- Who should treatment be targeted at? I.e. at what risk level?
- What should treatment target? I.e. the criminogenic needs which pertain to individuals at this targeted risk level
- What styles, modes, and strategies of service should be used? – ie what strategies match with the learning abilities and personality of the targeted offenders (responsivity).

Since the early work on RNR, various studies have been undertaken to further develop the three core principles of effective treatment. In their latest work, Andrews and Bonta outlined that the three core principles are accompanied by ‘overarching principles’, ‘additional clinical principles’, and ‘organisational principles’ (Andrews and Bonta, 2010; Andrews, Bonta and Wormith, 2011). Overarching principles include (a) respect for the person and the normative context, (b) basing the programme on empirically validated psychological theory, and (c) the importance and legitimacy of services that prevent crime, even when those services are located outside the criminal justice system. Additional clinical principles state that programmes should target multiple criminogenic needs (breadth), should assess strengths, both for risk prediction and responsivity, use structured assessments of risk, and use professional discretion occasionally on well-reasoned and well-

documented grounds. Organisational principles recognise intervention contexts and the resources needed for treatment. Andrews and Bonta, (2010) stated that community-based interventions are preferable, that staff practice both the relationship and structuring principles with offenders, and that management must provide, develop, and support the staff and other resources needed. As such, it is important to pay attention to staffing, management, and organisational concerns and the selection, training, and clinical supervision of staff in relation to assessment and relationship skills is very important. Nevertheless, the three principles of risk, need, and responsivity remain the cornerstone for effective rehabilitation (Andrews and Bonta, 2010). Without adherence to these factors even the best supported of evidence-based programmes may fail in “real world” settings (Barnoski 2004; Andrews and Dowden 2005; Andrews 2006).

1.5 The effectiveness of the RNR model

Andrews *et al.*, (1990) hypothesized that programme adherence to the three principles would be strongly associated with reduced recidivism. A review of 80 studies yielding 154 effect size estimates found a significant relationship between level of adherence to the RNR principles and reduced recidivism. Adherence to all three principles had a mean effect size (phi coefficient) of .30, whereas programmes which failed to attend to any of the principles actually showed an increase in recidivism (phi= -.06). These findings have subsequently been confirmed by a number of reviews (Andrews and Bonta, 2006).

1.6 The RNR model: application to sexual offending

Hanson, Bourgon, Helmus, and Hodgson (2009) investigated whether the RNR model for general offenders also applied to sex offenders. Their findings confirmed results from the general offending literature; programmes which adhered to the principles of RNR produced better outcomes than those which did not. Based on a meta-analysis of 23 recidivism outcome studies, the unweighted sexual and general recidivism rates for the treated sexual offenders were lower than the rates observed for the comparison groups (10.9% [$n = 3,121$] versus 19.2% [$n = 3,625$] for

sexual recidivism; 31.8% [$n = 1,979$] versus 48.3% [$n = 2,822$] for any recidivism). Programmes that adhered to the RNR principles showed the largest reductions in sexual and general recidivism. Given the consistency of the current findings with the general offender rehabilitation literature, the authors concluded that the RNR principles should be adhered to in the design and implementation of treatment programmes for sexual offenders.

As has been shown above, there is only one rehabilitation model which has been proven to be effective with a range of different client groups including sexual offenders - the RNR model. As such, it was selected to inform the development of the BNM programme. However, the applicability of the RNR model to the development of a treatment approach for IDSOs has never been examined. Can the RNR model be successfully applied to the treatment of IDSOs? This is the research question in this thesis. In order to answer this research question it is important to determine how treatment success will be determined.

1.7 Evidencing treatment effectiveness.

In order to evidence programme effectiveness, two main forms of evaluation have been proposed. Outcome evaluations examine the extent to which the programme or service is achieving the outcomes it sets out to achieve. In the case of rehabilitation programmes for offenders, outcome evaluations would examine whether the programme reduces reoffending. Process evaluations describe how a treatment approach is being implemented. These evaluations compare the actual delivery of the service against the standards that the service needs to meet. Travers and Mann (2011) argue that both types of evaluation are needed to determine the effectiveness of correctional programmes; outcome evaluations on their own provide little information about the nature of the treatment approach or how it can be improved, and similarly, process evaluations on their own provide little insight into whether treatment has achieved its aims.

Outcome evaluation: Various different methods for evaluating treatment outcome with sexual offenders have been outlined by Harkins and Beech (2007). As Harkins and Beech stated; “Each of these designs offer advantages, but also have methodological shortcomings” (p37). A full review of evaluation methods is beyond the core of this thesis. As such, a summary of the approaches and their application to correctional settings is provided below.

The randomised control trial (RCT) is believed by many researchers to provide the most conclusive evidence of treatment effectiveness. By assigning participants randomly to treatment or control groups, any pre existing differences between groups are controlled for. The random allocation process should mean that with sufficient people undertaking the intervention there will be no bias or systematic difference between the two groups being compared. As such, any observed differences can be attributed to the effect of treatment. However, Harkins and Beech reported that there are several limitations of randomised control research designs. Most large institutional systems, such as NOMS, are reluctant to approve of the random allocation of dangerous sexual offenders to a non treatment group for various reasons, not least ethical reasons relating to the need to protect the public. As such, in practice, this level of outcome evaluation can be expensive and challenging to achieve and consequently RCTs are rare in correctional research (Travers and Mann, 2011). But there are also limitations relating to the validity of the approach. Harkins and Beech reported that differential attrition rates between treatment and control groups could pose a threat to the internal validity of the study. Further, the generalizability of the findings to other treatment interventions is limited by the need for strict standards of participant selection and the need to maintain treatment integrity. Only one adult sex offender treatment programme study has utilised a RCT design. Marques, Wiederanders, Day, Nelson and van Ommeren (2005) conducted a longitudinal study using random assignment to treatment and control groups. The results of this study failed to demonstrate any significant effects for the treatment group.

In the absence of the RCT, it has also been advocated that treatment outcome studies should ensure that comparison groups are used as controls. Indeed, Marshall, Anderson and Fernandez (1999) argued that “less stringent criteria in terms of research design can yield meaningful inferential results in light of potentially unethical research and the creation of more unnecessary victims as the alternative” (as reported in Harkins and Beech, 2007; p37). Some studies simply compare a group of treated offenders with a group of untreated offenders. The better outcome studies involve comparing two groups who are “matched”. That is, the groups are shown to share similar, relevant characteristics, but one group undertook the treatment intervention and the other did not. Rice and Harris (2003) noted that the only acceptable way to achieve comparability is by matching on factors which have been empirically demonstrated to relate to recidivism. The process of selection of the treated and untreated groups does pose a threat to the internal validity of the research design (Harkins and Beech, 2007). Differences between the groups may be related to outcome in some way which has not been controlled for.

Practically, generating a comparison group research design can be problematic within correctional work. Given that successful completion of treatment is often considered favorably by decision makers (e.g. the Parole Board), it is unlikely that the comparison group would be treated in the same way as the treated group. This would substantially weaken the research design. Furthermore, there is no current screening for intellectual disability within HM Prison establishments or Probation trusts. As such, it is not known who does or does not have intellectual disabilities. Introducing a screening assessment for all would be costly and resource intensive, yet without access to this information a comparison group research design is not feasible. As an alternative to this, waiting list research designs have been proposed. However, this approach is also difficult to achieve within HM Prison and Probation environments. BNM treatment is lengthy, it requires nearly a year to complete (in custody) and often nearly two years in the community. If an offender volunteers to take part in treatment, it is policy that he is assessed and is placed in

treatment when a space becomes available. Priority is given to the higher risk cases and the length of time left to serve. Generally speaking there are few assessed men who spend a year or more waiting for treatment. As such, a waiting list design control group is not feasible. Furthermore, given the prioritisation of places to higher risk offenders, it is likely that the waiting list control group would have different characteristics to the treatment group, thereby affecting the likely outcome data.

Another way of evaluating effectiveness across various methodologies is meta analysis. Meta analytical research designs combine the results from a number of studies to determine if there is an overall effect amongst the studies as a whole (Harkins and Beech, 2007). By combining studies, a meta-analysis increases the sample size and thus the power to study effects of interest. This approach has received widespread attention in relation to the treatment of sexual offenders (e.g. Hanson Gordon, Harris, Marques, Murphy, Quinsey and Seto, 2002, Losel and Schmucker, 2005) and has led the way in terms of determining what is/ is not effective in their treatment. As with all research designs there are limitations with meta analysis. For example, the nature of the research design means that it is reliant on relevant published studies. As such, selection errors can be a concern. Publication bias may also be an issue given that research findings are more likely to be published if they are significant. To date, meta analysis has not been used in relation to the treatment of IDSOs due to difficulties with the number of methodologically rigorous studies available with this group.

There is an additional matter which serves to further complicate outcome evaluation studies on sexual offenders. This is associated with the difficulties of finding statistical significance. Abracen, Looman, Ferguson, Harkins, Mailloux *and Serin* (2011) described how the base rate for sexual recidivism is relatively low, with Hanson and Bussiere's (1998) meta analyses indicating that 13% of sexual offenders recidivate with a sexual offence over an average follow up period of four to five

years. As such, it is very difficult to demonstrate statistical significance unless very large groups are used or there is an extremely low recidivism rate in the treatment group.

Whilst it is, of course, important that treatment is found to have a significant impact on reoffending rates, even if recidivism is reduced, a treatment programme would be of little value if most withdrew during treatment. Thus, another way to establish treatment effectiveness is to monitor variables relating to participation in treatment, especially the number of participants who start treatment, but fail to complete; the “non completers.” Participants who fail to complete treatment can have numerous consequences, including not benefiting fully from services, which may be linked to diminished treatment outcome and decreased client satisfaction (McMurran, Huband, and Overton, 2010; Wierzbicki and Pekarik, 1993). Ensuring that sexual offenders remain in treatment is particularly critical given the relationship of treatment failure to reoffence risk. Hanson and Bussiere (1998) found that men who started treatment but failed to complete, were at increased risk of recidivism. Indeed, McMurran and Theodosi (2007), who conducted a meta-analysis of 16 correctional programme studies found higher rates of recidivism among the non completers. The authors concluded that not only are the non completers a higher risk than untreated offenders, but that “those who do not complete treatment are actually made worse” (McMurran and Theodosi, 2007, p. 341). Sexual offenders in HM Prison and Probation Services are aware that successful attendance on a treatment programme is likely to be considered favourably in any decision making about progression through the system or parole. As such, this leverage is likely to contribute to higher rates of completion in treatment. Indeed, previous internal reviews of sex offender treatment programme completion rates in HM Prison Service suggest that the average non completion rates are less than 10% (Interventions and Substance Misuse Group, 2009).

Finally, another method for evaluating treatment outcome is to assess whether or not participants meet the goals of treatment i.e. do treatment participants demonstrate changes in the areas of criminogenic need that the treatment was targeting? Harkins and Beech (2007) suggested

that treatment effectiveness should not only examine “ultimate outcomes of interest (i.e. recidivism rates)”, it should also look at “proximate outcomes” (p37), whether or not treatment brings about change. As such, it is suggested that effectiveness is evaluated by examining change from pre- to post-treatment on measures that assess functioning on the targets of treatment. Such pre – post design treatment evaluations are commonplace within correctional services, including treatment programmes for IDSOS (e.g. Hays, Murphy, Langdon, Rose, and Reed, 2007; Williams, Wakeling and Webster, 2007). There are a number of shortcomings to this research design. Firstly, without looking at recidivism, the question about effectiveness in relation to reconviction remains unanswered. Furthermore, the lack of comparison group means that it is not possible to establish whether or not changes would have occurred regardless of treatment intervention. Finally, the quality of these studies is limited by the psychometric tests that are used to determine whether or not treatment has impacted on the targets of treatment. This is of particular concern in relation to the treatment of IDSOS, for whom there are very few psychometrics available which assess treatment targets.

Process evaluations: Unlike outcome evaluations, process evaluations often use practice wisdom to help identify the links between process and outcomes. Evaluations of treatment processes are essential in order to identify the “active ingredients” of treatment (World Health Organisation, 2000). Process evaluation is most effective when it is implemented in conjunction with outcome evaluation. Knowing what actually occurred as the programme was implemented enables a greater understanding of the conditions that are responsible for a given outcome. In relation to correctional programmes, Travers and Mann (2011) argue that process evaluations should be completed alongside outcome evaluations. In today’s economic climate, with the financial pressures that exist, it is important that both types of evaluation are used to assist a programme in being accountable to its funders and other stakeholders. The socio - political context

in which any work with offenders takes place ensures that attempts to rehabilitate offenders are subject to a high level of scrutiny (Day, Casey, Ward, Howells and Vess, 2010).

In summary, therefore, the measurement and identification of effectiveness is quite complicated. A number of different research designs have been outlined and the various strengths and limitations described. There are two main evaluation processes which help inform treatment developers about programme effectiveness; outcome and process evaluation. Both approaches are important in enabling treatment programme developers to provide an evidence base to support the continued investment in a treatment approach. Furthermore, both approaches will add to the literature base and advance our understanding about treatment approaches for IDSOs. Webster and Marshall (2004) argued that qualitative and quantitative approaches should be used to complement each other, describing a need for “triangulated” inquiry methods from which effective judgements can be made.

1.8 Outline of the thesis

In chapters 2, 3 and 4, the literature concerning each of the three principles of the RNR model will be examined in turn. The applicability of the literature to IDSOs will be described and suggestions for treatment programme design will be outlined. Any gaps in the literature pertaining specifically to this client group will be identified and suggested accommodations for programme design will be made. In chapter 5, the development of the Becoming New Me treatment approach, in line with the suggestions for practice identified in the literature review (Chapters 2, 3 and 4) is provided. In chapter 6, the research studies, aims and hypotheses are presented. Given the lack of measures to assess the criminogenic needs of IDSOs (identified in the chapter 3), chapter 7 outlines the development and validation of a new battery of measures. In chapter 8, treatment participants pre and post scores on the newly developed and tested assessment measures are analysed and reported. This chapter therefore, provides the outcome evaluation. In Chapter 9, a process evaluation is described based on focus group discussions with treatment participants and

therapists. Chapter 10 comprises a summary of the major findings of the thesis and provides some suggestions for further research.

1.9 Conclusions

In this chapter the significance of sex offending by those with intellectual disabilities has been outlined. Yet, there has been little research undertaken on this specific client group. There is therefore, a need to fill this gap in the research. The aim of this thesis is to advance our understanding of the assessment and treatment of intellectually disabled sexual offenders. The offender rehabilitation literature highlights the risk needs responsivity model as the only empirically validated guide for offender interventions (Polaschek, 2012). The RNR model has been successfully applied to many offender groups, yet its applicability to IDSO treatment is not yet known. As such, the research question for this thesis is; can the RNR model be successfully applied to the treatment of IDSOs? Given this research question, it was important to review various treatment evaluation research designs. Following a review of the literature, and consideration of various practical issues relating to working in correctional settings, a research design which incorporated both an outcome and a process evaluation was planned. As such, this thesis provides a triangulated research design which serves to increase our understanding about treatment effectiveness for IDSOs, and provide the evidence base to support the BNM treatment approach.

Chapter 2: The applicability of the risk principle to the treatment of IDSOs

2.1 Introduction

Little is known about the applicability of the RNR model to the treatment of IDSOs. In the following three chapters, the literature pertaining to the three principles of effective offender rehabilitation will be described. In this chapter, the literature pertaining to risk in relation to sexual offending, and where applicable to IDSOs, will be outlined.

2.2 The Risk principle

The risk principle dictates that the level of service should be matched to the offender's risk to re-offend. More specifically, higher risk offenders should receive more intensive and extensive services, whereas lower risk clients should receive minimal or no intervention. This presupposes that the assignment of cases to treatment is based on a reliable and valid assessment of risk. To what extent does the literature support the applicability of risk assessment to IDSOs?

There are three major ways of assessing risk posed by sexual offenders which Bonta (1996) described as “generations” of risk assessment. The first generation of risk assessment involved unstructured clinical judgement; the second generation involved structured empirically based approaches of static risk; and the third generational tools involved combined assessment protocols which allow for the assessment of static risk and criminogenic needs.

Most experts agree that there is little place for the first generational approaches. Unstructured, subjective, clinical judgements, typically involved a practitioner reviewing information on an offender and then using his/her judgement to determine the risk that individual posed. However, when tested empirically this type of approach demonstrated poor reliability and validity, with high rates of error among even the most experienced risk assessors (e.g., Grove *et al.*, 2000). Structured

empirically based assessments provide better predictive accuracy than unstructured clinical judgment in general (Ægisdo'ttir, White, Spengler, Maugherman, Anderson, Cook, Nichols, *et al.*, 2006; Grove, Zald, Lebow, Snitz, and Nelson, 2000) and this conclusion holds equally in the assessment of offender risk for further crime (Andrews, Bonta, and Wormith, 2006; Hanson and Morton-Bourgon, 2009; Mann, Hanson and Thornton, 2010).

The structured empirically based risk assessment tools focus on static risk factors. Static risk factors, are fixed aspects of offenders' history which cannot be changed by their own efforts (such as age and the extent of previous offending). The second generation of risk assessments involved explicit, structured approaches to combining static, historical factors into an overall risk score. The items for second-generation instruments were selected based solely on empirical relationships with recidivism. The most commonly used risk tools for sexual offenders, such as Static-99 (Hanson and Thornton, 2000) or Risk Matrix-2000 (Thornton *et al.*, 2003), are classic examples of second-generation risk tools. Although static risk factors do change (e.g. offenders get older), these factors are generally not suitable targets for treatment intervention. As such, although second generational instruments which assess static risk are more accurate than unstructured clinical opinion (Hanson and Morton-Bourgon, 2009), they do little to inform how treatment should be planned or focused. Third generational tools aim to fill this gap. They provide guidance on the factors to which treatment should attend. Targets for treatment intervention are described as "criminogenic needs" (these are described in chapter 3). There is some evidence that assessments which combine an assessment of static risk with an assessment of criminogenic needs do bring some improvement to the predictive accuracy of the assessment (Andrews *et al.*, 2006; Hanson and Morton-Bourgon, 2009).

2.3 Assessment of static risk in sexual offenders and in IDSOs

Over the last 20 years, there has been a strong focus on developing static risk assessment tools for sexual offending. Most of the risk assessment tools were developed on large samples of sexual

offenders. In many cases, these sample groups have contained offenders with ID, but unfortunately, the studies have not controlled for this variable, so it is difficult to know to what extent such risk instruments can be applicable to IDSOs. Research with this client group has been limited in comparison with the quantity of mainstream research on the prediction of reoffending (Harris and Tough, 2004; Lambrick, 2003; Lindsay and Beail, 2004).

Craig and Hutchinson (2005) commented on the inapplicability of risk assessment scales when they are applied to individuals with characteristics that differ from the original sample on which the research was based. Grubin and Wingate (1996) have also argued that empirical evidence from one population does not necessarily translate to another. Blacker (2009) suggested that IDSOs may differ in some notable ways from the data cohort on which risk assessments have been developed. Firstly, she noted that the legal system is not as keen to investigate sexual offence incidents committed by ID individuals, thus reducing the likelihood of legal prosecution, which subsequently affects base rate data (Swanson and Garwick, 1990). Furthermore, she argued that IDSOs are often dealt with by the Mental Health system, rather than the Criminal Justice System, depending on victim factors (i.e. prosecution is more likely if the victim is male and a child), than on the nature of the offence (Green, Grey and Willner, 2002). Blacker also noted that some items within the actuarial tools, for example, the Risk Matrix 2000 (Thornton *et al.*, 2003), include risk factors such as having a male victim or relationship status. The presence of such factors incrementally increases the risk category. Blacker noted that the offence characteristics of IDSOs have been reported as different to non ID sexual offenders, and it has been observed that IDSOs tend to offend against more male victims than non-ID sex offenders, and their offences tend to be less serious (Brown and Stein, 1997). Similarly, IDSOs have been found to have poor peer relations, a lack of social sexual knowledge, negative early sexual experiences, and a confused self-concept (Hayes, 1991). Day (1994) examined the profile of IDSOs and found that prominent features of this group included sexual naivety, poor impulse control, inability to understand normal sexual

relationships, and a lack of relationship skills. Circumstance and opportunity, rather than sexual preference, appeared to be the overriding factors in the choice of victims in the majority of cases. Lacking an emotional relationship would therefore instantly place intellectually disabled offenders in a higher risk category.

Despite all this, some attempts to apply the risk assessment tools developed for non ID sexual offenders to ID sex offender groups have been made. These are reported below. Quinsey, Harris, Rice, and Cormier (2006) used the Violence Risk Appraisal Guide (VRAG) to predict recidivism in a variety of populations, including ID offenders. The VRAG is a 12-item actuarial tool developed to predict the likelihood of violent or sexual reoffending. It was developed with a heterogeneous sample of psychiatric and non-psychiatric offenders. In the construction sample, the VRAG had an area under the curve (AUC) of 0.79 among those with IQs less than 85 (Quinsey *et al.*, 2006). Recently, a modified version of the scale was used to predict violence in a small group (n = 58) of ID offenders released to the community over the course of an average of 15 months. With this group, the VRAG had an AUC of 0.69 in predicting violent and sexual reoffending in supervised settings (Quinsey Book, and Skilling, 2004).

Harris and Tough (2004) used the Rapid Risk Assessment of Sexual Offence Recidivism (RRASOR; Hanson, 1997). The RRASOR is an actuarial instrument which consists of only four items; prior sexual offences, sex of victim, relationship to victim, and age at time of offence. The authors found that it performed better than the most well known actuarial measure Static-99 (Hanson and Thornton, 2000), and was able to differentiate recidivists from non-recidivists, having good estimates for overall risk based on a sample of 76 intellectually disabled sex offenders.

Boer, Tough and Haaven (2004) recommended that in addition to RRASOR, the PCL R should be used to assess this client group (Hare, 1991, Hare 2003). Morrissey (2010) argued that the PCL R needs to be adapted when used with those with ID. She developed a set of guidelines for use when

undertaking PCR assessment with this client group. The guidelines provide comparative examples for making assessments and judging “normal” in this client group. Morrissey *et al.*, (2007) reported that the rate of psychopathy (as measured by PCL R) was significantly higher in a group of offenders in high security settings than in a group of offenders in the community. This result is probably to be expected, it suggests that measured psychopathy in this client group follows the same pattern as in non- ID offenders.

Lindsay, Hogue, Taylor, Steptoe, Mooney, O’Brien, Johnson, and Smith, (2008) investigated a number of risk assessments with this client group. They compared the VRAG, HCR 20, Static 99 and Risk Matrix 2000. They used these instruments across three levels of security; high, medium/low, and in a community setting. The hypothesis used in the study was that the risk assessments should reflect the level of security within each cohort; that is, those in high security should show significantly higher risk than those in lower security settings and so forth. The study also looked at two further assessments that have been shown to be predictive of violent incidents. These assessments look at dynamic variables. The assessments are the Short Dynamic Risk Scales (SDRS; Quinsey *et al.*, 2004) and the Emotional Problems Scales (EPS; Prout and Stohmer 1991). In addition to the assessment instruments, violent and sexual incidents were recorded over a period of 12 months. Results showed that the VRAG, HCR 20H and RM2000-C had significant difference between groups. For the dynamic risk assessments only the EPS Internalising showed significant differences across groups. In terms of predictive accuracy for violent incidents, the VRAG and the HCR 20 showed significance. RM 2000-V fell just short of significance. All of the dynamic predictors had significant predictive value. For sexual incidents the Static 99 achieved significant predictive value, the RM 2000-S fell just short of significance. The RM2000 results are described by the authors as being disappointing, but worthy of further research.

Wilcox, Beech, Markall and Blacker (2009) compared three mainstream risk tools: the RRASOR, Static-99 and RM2000-Sexual on a sample of 27 treated intellectually disabled sex offenders, and

found that the Static-99 had a lower AUC than found in a study by Lindsay *et al.*, (2008). Overall, the Static-99 had the highest AUC of .64, followed by the RM2000-S (AUC of .58), which was lower than that found by Lindsay *et al.*, (2008). The predictive validity of the RRASOR produced the poorest score (AUC of .42).

In drawing conclusions from the studies presented above, caution is advocated. Blacker (2009) suggested that the results may be attributable to differences in the statistical procedures used, and differences in the severity of the intellectual deficits. In Tough's sample, all of the participants had significant cognitive deficits, whereas the Wilcox *et al.*, sample included men with mild intellectual disabilities. Boer, Tough and Haaven (2004) suggested that the risk level determined by a risk assessment tool should provide the "risk baseline" for risk or risk management assessments. This assessment of static risk they suggest should "serve as a decision factor in deciding treatment intensity level and supervision intensity level (higher risk, higher intensity etc)" (p278). They go on to suggest that the risk baseline assessment can be used to anchor decisions regarding risk after treatment.

Nevertheless, Harris and Tough (2004) reported "there is no scientific reason to believe that static and stable factors that reliably predict risk for a normal offender will not reliably predict risk for offenders from the intellectually disabled population. Indeed, what data exists (Tough, 2001) suggests that these same factors predict quite well within the intellectually disabled population" (p237). Similarly, Wilcox (2004) argues that risk factors contained within risk assessment tools can apply to intellectually disabled sex offenders, given that initial research to identify risk factors associated with reconviction was based on large offender populations, which would have been normally distributed in terms of intelligence, and that subsequently, a proportion of them would have had intellectual disabilities.

In summary, there are no risk assessment measures which have been specifically developed and normed for IDSOs (Lambrick and Glaser, 2004; Camilleri and Quinsey, 2011). A general view is that research needs to be undertaken in relation to determining the risk factors related to sexual reoffending in IDSOs. Until this work is completed however, researchers agree that the risk factors among sex offenders with or without ID are likely to be quite similar. In the light of this conclusion, the Criminal Justice agencies (The Prison, Probation and Police services) in England and Wales are justified in using Risk Matrix 2000 (Thornton *et al.*, 2003) to describe the level of risk of sexual offending based on historical static factors. There is no reason at this time to suppose that the RM2000 is any more or less applicable to this client group than any other of the available risk assessment tools. Indeed as Lindsay *et al.*, (2008) suggested, given that it is relatively easy to administer, it is an attractive option for busy clinicians in criminal justice settings.

2.4 Risk Matrix 2000 (RM2000)

The RM2000 is a static risk assessment tool for use with adult males who have been convicted of a sexual offence. At least one of the sexual offences must have been committed when the offender was over 16. The RM2000 sex scale (RM2000/s) predicts sexual recidivism and is made up of seven items divided into two scoring steps. Step one comprises three items: Age of the offender on release, number of sentencing occasions for a sexual offence and number of sentencing occasions for any criminal offence. The scores assigned to each of these items are summed and translated into one of four preliminary risk categories: Low, Medium, High or Very High. The second scoring step considers four risk-raising items (aggravating factors): Whether the offender has any male victims of sexual offending, whether any of the offenders' victims were strangers, whether the offender has ever had a stable live in relationship for over two years (termed the 'single' item), and whether the offender has ever committed a non contact sexual offence. These items are scored on a dichotomous scale as either present or not. If two or three of these items are present the initial risk category is raised one level (e.g., from Low risk to Medium). If all four of

these aggravating factors are present the initial risk category is raised by two risk levels (e.g., from Low to High). A number of studies have indicated that the RM2000/s has good predictive validity with UK samples (Barnett, Wakeling and Howard, 2010; Craig, Beech and Browne, 2006; Grubin, 2008; Thornton *et al.*, 2003). Table 2.1 below shows the 2 and 4 year sexual reconviction rates broken down by RM2000/s categories. The table highlights the low base rate for sexual reoffending (particularly in the lower risk RM2000 category).

Table 2.1

Two and four year sexual reconviction rates by RM2000 category (reproduced from the RM2000 scoring guide, Thornton, 2010)

RM2000/S Category	2 Year (n=4946)	4 Year (n=578)
Low	1%	1%
Medium	2%	3%
High	3%	9%
Very High	7%	27%

RM2000 is used with all sexual offenders across the Criminal Justice Service, including those with ID. Indeed, the sample on which the RM2000 was developed did include men with ID (Thornton, personal communication), but the tool has not been specifically validated for use with this group.

2.5 Conclusions.

This chapter has focused on the risk principle. There is now a sound base of knowledge about risk in relation to the assessment of non ID sexual offenders. Unfortunately this work has not been specifically applied to those with ID. There are no reliable measures which have been developed and normed specifically on IDSOs (Lambrick and Glaser, 2004; Camilleri and Quinsey, 2011).

However, researchers agree that the risk factors among sex offenders with or without ID are likely

to be quite similar. There is no reason to suspect that there will be any major differences. As such, the Criminal Justice agencies in England and Wales are justified in using Risk Matrix 2000 (Thornton *et al.*, 2003) to describe the level of risk of sexual offending based on historical static factors. The use of RM2000 to determine the risk of reoffending for IDSOs is therefore supported as part of the BNM treatment approach.

Chapter 3: The applicability of the Need principle to the treatment of IDSOs.

3.1 Introduction

Although the assessment of risk is useful in determining offenders who are at a higher or lower risk of reoffending, it cannot be used to determine what should be changed in order to lower risk (Beech *et al.*, 2003). Further, risk assessment tools do not enable a reappraisal of risk following intervention. To achieve these objectives, recent attention has turned to the “predictive ability of factors that are fairly stable but have the potential to change” (Harkins and Beech, 2007; p617). These factors are known in the literature as “criminogenic needs” and are the focus of this chapter.

3.2 The criminogenic needs of sexual offenders

There have been a number of notable contributions to our understanding of criminogenic needs in non ID sexual offenders. Mann, Hanson and Thornton (2010) describe how three important studies have given insight into the criminogenic needs presented by sexual offenders: Hanson and Morton-Bourgon’s (2004) meta-analysis of dynamic predictors of sexual recidivism; Knight and Thornton’s (2007) analysis of predictors of recidivism in the Bridgewater dataset; and Hanson, Harris, Scott and Helmus’ (2007) assessment of recidivism predictors in the Dynamic Supervision Project. In summarising the results from these three studies, the criminogenic needs which are strongly related to sexual recidivism can be attributed to four areas; Offence related sexual interests, offence supportive attitudes, socio affective functioning and self management. Each area will be briefly outlined below.

Offence related sexual interests refer to the direction and strength of the sexual attraction. These include; Sexual preoccupation (an intense interest in sex that tends to dominate psychological functioning), sexual preference for pre-pubescent or pubescent children, sexualised

violence (either a preference for coercive sex over consenting sex or sadistic sexual interest) and an interest in multiple paraphilias (e.g. exhibitionism, voyeurism, cross-dressing).

Offence-supportive attitudes refer to the offender's beliefs regarding offences, sexuality or victims that justify sexual offending (Thornton, 2002). These attitudes showed a small but statistically significant relationship with sexual recidivism in Hanson and Morton-Bourgon's (2004) meta-analysis. Offence supportive attitudes observed in child molesters include beliefs that children can enjoy sex, that adult-child sex is harmless, or that children can be sexually provocative (Mann, Webster, Wakeling and Marshall, 2007). Rapists may evidence beliefs that rape is justified, harmless, or even enjoyable for the woman.

Socio affective functioning refers to how one interacts with others and the emotions that motivate these interactions (Thornton, 2002). This area refers to emotional congruence with children (when an offender feels that relationships with children are more emotionally satisfying than relationships with adults). A lack of ability to form emotionally intimate relationships with adults has a significant relationship with recidivism (Hanson and Bussiere, 1998; Hanson and Morton-Bourgon, 2004). This area also includes grievance/hostility (the perception of having been wronged by the world, feeling that others are responsible for their problems, and wanting to punish others as a consequence). Individuals have difficulty seeing other people's point of view, they believe that others have wronged them, and they anticipate further wrongs will be perpetrated against them.

The Self Management area refers to an individual's ability to plan, problem solve and regulate impulses which are important to achieving long term goals (Thornton, 2002). It includes lifestyle impulsiveness (a lifestyle dominated by impulsive, irresponsible decisions with a lack of realistic long term goals); resistance to rules and supervision (including rule violations, non-compliance with supervision, and violation of conditional release which are large predictors of sexual recidivism),

and negative social influences and poor problem solving are also significant in relation to recidivism outcomes.

In summary, the large scale meta-analyses of predictors of sexual offender recidivism have enabled a sound base of knowledge about criminogenic needs of sexual offenders. Researchers agree that to date, there is no research to suggest that the criminogenic needs of IDSOs are any different to those of non ID sexual offenders (Langdon and Murphy, 2010).

3.3 Assessment of criminogenic needs in sexual offenders.

As described earlier in chapter 2.2, Bonta (1996) identified three generations of risk assessment. The third-generational tools are designed to assist intervention efforts. Third-generation assessments are empirically validated actuarial measures that include criminogenic needs. Several third-generation risk tools have been developed for general offenders (e.g., Level of Service/Case Management Inventory, Andrews, Bonta, and Wormith, 2008); only recently, however, has research focused on third-generation instruments for sexual offenders. The assessments that do exist are presented in different ways. Some risk assessment algorithms incorporate both static and dynamic variables within the same instrument (e.g. Sex Offender Risk Appraisal Guide: Quinsey, Rice, and Harris, 1995). Others have been developed that purely comprise dynamic factors (e.g. Sex Offender Needs Assessment Rating: Hanson and Harris, 2001; Estimate of Risk of Adolescent Sexual Offence Recidivism: Worling, 2004). It is essential that both types of risk predictor framework meet conventional psychometric standards of reliability and validity and do not exceed their position in the claims they make about the likelihood of future sexual offending.

3.4 The Structured Assessment of Risk and Need (SARN)

HM Prison Service of England and Wales developed an instrument that enables clinicians to evaluate treatment need and change in sexual offenders, the Structured Assessment of Risk and

Need (SARN: Thornton, 2002). The SARN is a clinical framework for evaluating static risk, and then structuring clinical judgement about dynamic risk and treatment change. First, static risk is measured using Risk Matrix 2000 (Thornton, Mann, Webster, Blud, Travers, Friendship, and Erikson, 2003). In SARN terminology, criminogenic needs are referred to as “treatment needs” because the SARN is first and foremost a treatment planning tool. All treatment needs within the SARN have been linked via published empirical research to recidivism (Thornton 2002).

The SARN utilizes a scoring protocol that examines the relevance of each treatment need factor as present both in the proximal lead-up to the sexual offence, and/ or in the offender’s life generally. The basis for scoring each individual dynamic risk factor is set out in a scoring manual that defines each factor, summarizes the research base for its inclusion in the framework, and explains how the scoring system should be applied. Any factor which scores highly in both the lead up to the offence and in the offender’s life generally is defined as a relevant treatment need area for the offender. The SARN framework has been shown to be predictive with offenders under community supervision (Craig, Thornton, Beech, and Browne, 2007), with prisoners participating in sexual offender treatment (Thornton, 2002), and with sexual offenders being assessed for an earlier generation of civil commitment program (Knight and Thornton, 2007). As yet the applicability to sexual offenders with ID is assumed, not established.

3.5 The assessment of criminogenic needs in IDSOs

The research in relation to the assessment of criminogenic needs in IDSOs has lagged behind that of non ID sexual offenders, and has only started to develop over recent years. Lindsay, Taylor, and Sturmey (2004) describe how aspects of the general risk assessment literature such as the distinction between static and dynamic predictors, the utility of clinical judgment, and the predictive accuracy of risk assessments, can be applied to offenders with intellectual disabilities (Harris and Tough, 2004; Turner, 2000). Very little research has been undertaken using established third generational tools (developed with non ID populations) with IDSOs. There is general

agreement in the literature that research is scarce and authors suggest further work is required (Lindsay and Beail, 2004; Turner, 2005). A summary of the research pertaining to the assessment of criminogenic needs in this client group is described below.

Hanson *et al.*, (2007) investigated a large community sample using a specially designed criminogenic need assessment framework, the STABLE. As part of their analyses, they were able to assess the incremental validity of STABLE over and above Static-99 for a sub-group which combined offenders with ID and offenders who had a history of psychiatric hospitalisation. Interestingly, they found that Static-99 was significantly related to all types of recidivism, but consideration of the stable variables did not improve upon this prediction. This was in contrast to other groups of sexual offenders, where assessment of stable factors did make a significant incremental contribution to recidivism prediction. Hanson *et al.*, concluded that these results should be replicated before any firm conclusions could be drawn. They speculated that either sexual offending was linked to different criminogenic factors for the ID group, or the presentation of these offenders made it hard to determine which of their needs were criminogenic and which were not.

Boer, Tough and Haaven (2004) proposed a structure to assess the criminogenic needs of IDSOs, the Assessment of Risk Manageability for Intellectually Disabled Individuals who Offend – Sexually (ARMIDILO-S). The ARMIDILO-S assesses only criminogenic needs (the authors advocate that a static risk assessment tool is needed separately). The usefulness of the ARMIDILO - S is emerging. Blacker (2009) examined the predictive accuracy of four risk assessment instruments. She compared the Sexual Violence Risk Scale (SVR-20; Boer *et al.*, 1997), Risk Matrix 2000/ violence scale (Thornton *et al.*, 2003), the Rapid Risk Assessment for Sexual Offence Recidivism (RRASOR, Hanson, 1997) and the ARMIDILO (Boer, Tough and Haaven, 2004). The ARMIDILO (the only tool to include the assessment of criminogenic needs within the risk assessment) was the best predictor for sexual reconviction for her “special needs” group. Lofthouse, Lindsay, Totsika, Hastings, Boer, and Haaven (2013) compared the ARMIDILO-S with a static risk assessment for sexual offending

(STATIC-99), and a static risk assessment for violence (Violence Risk Appraisal Guide - VRAG) on a sample of 64 adult males with ID and a history of sexual offending behaviour. The use of the ARMIDILO, the only tool to assess criminogenic needs, resulted in the best prediction of sexual reoffending. These results would suggest that the inclusion of an assessment of criminogenic needs increases predictive accuracy with individuals with ID.

Together, these studies confirm that risk assessment instruments which incorporate criminogenic needs (third generational tools), are more accurate assessments in ID populations than those which rely on static assessment only. As described earlier, HM Prison and Probation use the Structured Assessment of Risk and Need (SARN) to assess all sexual offenders. This is a third generational tool which combines static risk assessment (RM2000) with an assessment of criminogenic need in line with the recently reported findings in the literature. The applicability of the SARN to IDSOs is yet to be established, but early research findings support the applicability of the SARN to this client group (K. Hocken, personal communication, 14.07.12).

3.6 Measuring criminogenic needs

Measurement of criminogenic needs can be problematic in all offender subgroups as any assessment often relies on clinical judgement and self-report. As a result, third generation assessments require that a range of sources of evidence are considered before any judgement about the presence, absence and/or strength of each dynamic factor is made. One such source of evidence comes from psychometric assessments which measure psychological characteristics. However, such assessments have been criticised for relying on accurate self-report, which can be affected by the offender's motivation to be open about his/her problems, and by an offender's level of insight into him/herself (Holden, Kroner, Fekken and Popham, 1992).

Despite these concerns, researchers have found links between self-report psychometric tests and subsequent sexual offending. Beech (1998), using samples of convicted sexual offenders about

to enter treatment, developed a method for identifying the severity of dynamic risk posed by individuals based on their pre - treatment psychometric test scores. One hundred and forty sexual offenders completed psychometric tests measuring various dynamic risk factors associated with sexual offending. Using agglomerative cluster analysis on the pre treatment scores, two clusters of offenders emerged. The mean scores for cluster A were significantly higher than the mean scores for cluster B on nine of the measures used. Cluster A was labelled 'High Deviancy', as their scores deviated highly from the non offender norms for these measures, while cluster B was labelled 'Low Deviancy'. Subsequent analysis found that High and Low Deviancy groups differed significantly in relation to the number and type of their previous victims, and risk of reconviction (as calculated from the offenders' offence histories).

Beech, Friendship, Erikson and Hanson (2002) in a sample of 140 convicted child abusers with a follow-up period of up to six years, found that psychometric deviancy level added incrementally to the predictive validity of a static risk assessment. Beech and Ford (2006) found similar results with a group of 51 sexual offenders attending a treatment clinic; High Deviancy offenders were more likely to be reconvicted at the two-year and five-year follow-up periods (13% and 44% reoffending respectively) than the Low Deviancy offenders (4% reoffending at two years and 10% at five years). Using a sample of child molesters attending treatment in New Zealand, Allan, Grace, Rutherford and Hudson (2007) reported that psychometric measures of offence-supportive attitudes and sexual interests predicted reconviction for a sexual reoffence, despite previous concerns about the face validity of these tests.

Taken together, these studies suggest that psychometric assessments of criminogenic needs can add to the predictive power of static risk assessments for sexual offenders. However, once again, there is very little information pertaining to the usefulness of psychometric assessment in determining criminogenic needs in IDSOs. Indeed, the literature pertaining to IDSOs identifies a number of potential confounding variables in relation to the use of psychometric tests with this

client group (Finlay and Lyons, 2002; Flynn, 1986). Clare (1993) discussed the difficulty that ID offenders have with complex language and concepts which are commonly inherent in sex offender assessments. She suggested that the discriminations involved in self-report questionnaires (such as those which use Likert scales) may prove problematic for ID clients to complete. Lindsay (2002) reported that many of the existing assessments for sex offenders are too linguistically complicated. He reported that it is likely that IDSOs may misunderstand the requirements of the test and the items presented. Assessments need to be adapted to meet the needs of the ID group. Lindsay warned that any measures which are adapted will need to have their psychometric properties re-established.

3.7 Conclusions

There is now a sound base of knowledge about the criminogenic needs of non ID sexual offenders. Unfortunately this work has not been specifically applied to those with ID, and once again, the applicability of this research to IDSOs is assumed, not established. In making predictions about the likelihood of recidivism, a combined assessment approach which focuses on both static risk factors and criminogenic needs is likely to be the most useful approach. A review of the combined approaches to risk/ need assessment has been outlined. In determining criminogenic need, treatment providers should look to a variety of sources for information. Psychometric assessments can be useful to help identify the presence, absence and/or strength of each criminogenic need for any given individual. However, psychometric assessments must be valid in order to be useful as an assessment tool. Currently, there are few psychometric tools which have been developed and validated for use with IDSOs. Of this small pool of tools, there are even fewer assessments which focus on the known areas of criminogenic need. Researchers have called for the development of measures to enable the accurate assessment of criminogenic needs in IDSOs.

Chapter 4: The applicability of the responsivity principle to the treatment of IDSOs

4.1 Introduction

Most of the research with sexual offenders has focused on issues related to the risk and needs principles (see chapters 2 and 3). There is now good empirical evidence to indicate “who” should be treated (risk) and “what” treatment they should receive (need). This chapter focuses on the final principle in the RNR model; responsivity. The literature pertaining to the “how” of delivery (responsivity) has been relatively neglected (Looman, Dickie and Abracen, 2005). There is a small body of literature relating to sex offender treatment generally, but the literature specific to the treatment of IDSOs is virtually non-existent. In order to advance our understanding about responsivity in IDSO treatment, a number of different literature bases have been reviewed. The key findings are presented within this chapter.

4.2 The responsivity principle

Responsivity factors are associated with the client’s ability to benefit from treatment and these have received little research attention (Looman, Dickie and Abracen, 2005). As Polaschek (2012) describes, responsivity “is theoretically unsophisticated: a catch-all category. Yet, it contains much of what makes the application of the model both humane and effective” (p8). She argued that the fact that responsivity is “under developed” may have important consequences for treatment. Arguably, it could be suggested that unless treatment is delivered in a way in which the client responds, there will be no impact on risk or need. Thus, the responsivity principle is a fundamental part of the RNR trinity and is worthy of greater research interest.

There are two types of responsivity factors; general and specific. Andrews and Bonta (2010) outlined “the general responsivity principle is quite straightforward: Offenders are human beings, and the most powerful influence strategies available are cognitive-behavioral and cognitive social learning strategies. It matters little whether the problem is antisocial behavior, depression, smoking, overeating, or poor study habits—cognitive-behavioral treatments are often more effective than other forms of intervention. Hence, one should use social learning and cognitive-behavioral styles of service to bring about change” (p 50). The emphasis here is on the treatment approach and the process adopted. It has also been suggested that the process of treatment can be influenced by other factors, for example, the therapeutic climate of the group, the composition of the group in terms of offender characteristics and also the characteristics and abilities of the therapist (Harkins and Beech, 2007). Looman *et al.*, (2005) argue that general responsivity (or “external responsivity”) involves both therapist and setting characteristics. The exact nature of general responsivity is not clearly defined. Researchers do, however, agree that general responsivity relates to factors which are external to the individual in treatment and impact on their ability to benefit from treatment.

Ware (2009) outlined the importance of contextual factors within sex offender treatment which he argued have received very limited research attention to date. In a review of the factors which have influenced outcome in offender treatment evaluations, Losel (2012) outlined a number of factors relating to programme and treatment context. The relevance of these factors speaks to the organisational principle which Andrews and Bonta (2010) included as part of their widening of the RNR concept (see chapter 1.4). These contextual considerations relate to conditions which are external to the individual in treatment and, as such, it is argued should be regarded as general responsivity factors. Yet, to date, these factors have not been presented in this way in the literature. In this thesis, the contextual factors surrounding treatment are included as part of the literature review on general responsivity.

In relation to specific responsivity, Andrews and Bonta (2010) stated “there are many specific responsivity considerations. For example, an insight-oriented therapy delivered in a group format may not “connect” very well for a neurotic, anxious offender with limited intelligence. Offender characteristics such as inter-personal sensitivity, anxiety, verbal intelligence, and cognitive maturity speak to the appropriateness of different modes and styles of treatment service” (p 50). As such, the specific responsivity factors refer to the individual characteristics of participants which make them more or less responsive to treatment.

Treatment programme designers must be mindful of both types of responsivity factors in the planning, development and evaluation of any treatment approach. In this review both general and specific responsivity will be explored.

4.3 General Responsivity

There are two literature bases from which information about general responsivity can be drawn. Firstly, the treatment outcome literature which identifies four general responsivity factors, and secondly, the process evaluation literature which provides information about responsivity based on the experience of treatment. Collins, Brown and Lennings (2010) noted “It seems logical that the offender’s experience of treatment would be canvassed in treatment outcome studies, but this is infrequently the case” (p291). There are few studies which have explored the participant’s view of treatment and consequently we know little about the offender’s experience in treatment. This is an area where researchers agree more work is needed. Wakeling, Webster and Mann (2005) suggest that participant input into programme evaluation and improvement is crucial to ensure treatment is responsive to participant needs. This view was echoed by Hays *et al.*, (2007) in regard to the views of IDSOs. As such, to enable a fuller understanding of the general responsivity principle, both outcome and process evaluations are reviewed.

The treatment outcome literature identifies four factors which have an influence on the general responsiveness. These can be categorised as; the treatment approach, the group environment, the characteristics of the therapist and treatment context. Each factor will be reviewed in turn.

4.4 The treatment approach.

Various types of treatment interventions have been applied in correctional settings. Many have not been evaluated, others have received some research attention. Losel (2012) provided a review of the controlled intervention evaluations for adult offenders, including the use of therapeutic communities, counselling, mentoring programmes and restorative justice.

Therapeutic communities provide a comprehensive approach to rehabilitation and have been implemented in custodial settings (Cullen, Jones and Woodward, 1997). Losel (2012) described how these communities contain a therapeutic climate and regime, which includes intensive contact between staff and inmates, sensitivity to group dynamics, various therapies, and the use of appropriate control and reward incentives. These environments have been shown to have overall positive effects with personality disordered offenders (see Lipton *et al.*, 2002). Positive effects have also been reported with general and violent offenders and drug-addicted offenders (Holloway, Bennett, and Farrington, 2008; Mitchell, Wilson, and MacKenzie, 2007; Pearson and Lipton, 1999).

Counselling approaches have also been used in offender populations to address problematic issues. Early meta-analyses did not support low-structured counselling and non-cognitive behavioural concepts of therapy (Andrews *et al.*, 1990; Lipsey, 1992), but more recently, researchers have shown more favourable outcomes (for example, Koehler *et al.*, 2011).

Mentoring approaches typically involve a non-criminal role model forming a relationship with an offender to provide guidance and advice. Meta-analyses on mentoring programmes for young offenders show small positive effects on aggression and delinquency (DuBois *et al.*, 2002; Tolan *et al.*, 2008), but there is not yet sound evidence that they reduce reoffending in the longer term (Jolliffe and Farrington, 2008).

Restorative justice approaches aim to encourage the reparation of harm caused to victims and other stakeholders. Offenders are encouraged to show insight into the harm they have done,

show remorse, and be willing to compensate (where appropriate). Systematic reviews show desirable effects on recidivism (Shapland *et al.*, 2008).

In conclusion, Losel (2012) noted that the best replicated findings of treatment success relate to cognitive-behavioural treatment (CBT). The mean effect sizes of therapeutic communities and counselling approaches are smaller than those of CBT programmes (Aos, *et al.*, 2001). It is, however, important to remember that there are various confounding variables which may impact on these results. For example, offenders in therapeutic communities are usually more challenging and at higher risk of reoffending than those in the CBT comparison studies. Evaluation of counselling approaches are often hampered by the nature of the approach itself. Counselling interventions are individualised, and as such difficult to compare across individuals. Restorative justice interventions appear to show much promise. However, in reviewing these approaches Losel noted how successful programmes contain many elements that are common in CBT (e.g. perspective taking, cognitive restructuring, and motivation to change). It seems therefore that successful treatment approaches, including CBT, incorporate a variety of methods which stem from interventions that have had some success in offender populations.

In CBT interventions causality is attributed to faulty cognitions and self regulatory capacities, leading to consequent deviant behaviour. The offender is helped to develop an awareness of the role of underlying beliefs, monitor automatic thoughts, test the accuracy of cognitions, develop new adaptive thoughts and assumptions and practice these in role plays (Allam, Middleton and Browne, 1997). CBT programmes have had undoubted success in the area of general offender behaviour. Meta-analyses have shown that CBT programmes are successful (see Koehler, Lösel, Akoensi, and Humphries 2011 for a review). Depending on the specific programme, target groups, research design and many other variables, CBT programmes can reduce reoffending by between approximately 10 - 30 per cent.

CBT approaches with sexual offenders have been found to be reasonably effective. Hanson (2002) conducted a meta-analysis of studies up until the year 2000. Forty three published and unpublished studies (N = 9,454) were included in the meta-analysis and the results were analysed to determine whether treatment was effective in terms of its impact on both sexual and general offending. Effectiveness in relation to type of programme (e.g., CBT, systemic) was also explored.

Hanson found the re offence rate of treated sexual offenders (12.3%) to be lower than the untreated sex offenders (16.8%). He also found that CBT was the most effective type of intervention. Treatment was also found to significantly reduce general offending, the reoffence rate for the treated group (27.9%) was lower than that for the untreated group (39.2%).

In another meta analysis, Hanson, Bourgon, Helmus, and Hodgson (2009) distinguished cognitive-behavioural approaches (including those with relapse prevention components) from other types of treatment. They concluded that it was only CBT that reduced recidivism. Losel and Schmucker (2005) also conducted a meta-analytical review of sex offender treatment. They increased the size of the sample pool to include 69 studies (N = 22,181) up until 2003, a third of which came from countries outside North America. The results supported the efficacy of treatment, with sex offenders reoffending at a significantly lower rate (11.1%) than the various comparison groups (17.5%). Similar results were evident for general offending, and they also found that CBT was more effective than other types of treatment.

However, as Marshall and Marshall (2010) point out, describing programmes as "cognitive-behavioural" implies a uniformity that does not appear to be present. McGrath, Cumming, Burchard, Zeoli, and Ellerby (2010) provided a review of sex offender treatment programmes which revealed considerable differences across programmes despite most respondents describing their programmes as CBT. Nevertheless, despite issues of precise definition, it is generally agreed that the most useful approach for sexual offenders is the cognitive behavioural approach. So much so that the "Practice Standards and Guide" set out by the Association for the Treatment of Sexual Abusers (ATSA, 2005), the international organization overseeing the provision of sexual offender treatment services, states that "contemporary treatment programs of sexual abusers employ cognitive-behavioral techniques" (p. 18).

But this by no means implies that CBT programmes might be equally effective with IDSOs. Psychological treatment approaches with intellectually disabled offenders have included psychotherapy, behaviour management, and cognitive and problem solving interventions.

Prout and Nowak-Drabik (2003) reviewed 92 studies of psychotherapy with intellectually disabled offenders. Only nine studies included a control group enabling meta analysis. The authors concluded that psychotherapy with this client group resulted in moderate change. They also found that individual interventions were more effective than other treatment options e.g. group interventions and treatments that took place in the client's home. This review has been criticised for various methodological problems including how the authors defined psychotherapy. Beail (2003) and Willner (2005) concluded that difficulties with the methodologies adopted in the literature make it difficult to draw conclusions about what constitutes effective psychotherapeutic practice.

Plaud *et al.*, (2000) suggested that the purpose of a behavioural treatment programme with this group is to improve daily living skills, general interpersonal and educational skills, and skills related to sexuality and offending. A number of studies have reported the use of behavioural techniques to improve the lives of IDSOs. In relation to sexual offending, a number of studies have reported improvements in sexual knowledge and understanding (for a review see Craig, Lindsay and Browne, 2010). A variety of behavioural techniques have also been used to reduce deviant arousal in this group, e.g. covert sensitisation, masturbatory satiation, aversive therapy and biofeedback, although little evidence exists to support the use of such techniques with ID sexual offenders (O'Connor and Rose, 1998).

There are no studies which show that cognitive therapy alone produces change with ID groups (Sturmey, 2006). The applicability of the cognitive behavioural approaches specifically designed with ID populations has been described in relation to the treatment of depression (Lindsay, Howells and Pitcaithly, 1993; Lindsay, 1999), anxiety (Lindsay and Baty, 1989; Morrison and Lindsay, 1997), anger control (Taylor, 2002; Whittaker, 2001; Rose *et al.*, (2005) and fire setting (Taylor *et al.*, 2005). Two reviews of psychological interventions for sexual offenders with ID have been undertaken (Lindsay, 2002 and Courtney and Rose, 2004). These reviews included behavioural management, problem-solving, psycho-educational and cognitive-behavioural approaches. Conclusions from these studies suggest that CBT approaches show promise, but evaluation studies have been limited; involving small, heterogeneous samples, utilising measures

with limited reliability and validity, using poorly defined outcomes, and incorporating treatment interventions that are often described vaguely and are multi-modal in nature (Lindsay and Taylor, 2005).

In summary CBT approaches appear to have some success with sexual offenders, but the responsivity principle states that any treatment approach must be adapted to accommodate the various learning styles of offenders will be more successful than those that do not (Andrews and Bonta, 1998). Placing lower IQ sexual offenders in treatment programmes with high IQ sexual offenders may contribute to feelings of inadequacy in the lower IQ offender, which decrease motivation to engage in the treatment process as well as promote disruptive behaviours that distract attention away from his cognitive deficits (Looman *et al.*, 2005). Therefore, poorer treatment outcome measured in terms of institutional adjustment, attrition, and treatment gain may be reflective of failure to adhere to the responsivity treatment principle. Indeed some studies have reported this. Ross and Fabiano (1985), for example, found that IQ was related to success in a cognitive behavioural treatment programme. They found that offenders with IQ levels lower than 85 might not successfully respond in a cognitive programme. Craig and Hutchinson (2005) report that non- ID cognitive behavioural programmes tend to have little impact on ID sexual offenders. Barron *et al.*, (2004) found little evidence for the efficacy of therapeutic interventions that were non specific to people with ID. Those with ID will experience frustration when trying to process new information. This can effect motivation. Indeed, Olver, Stockdale and Wormith (2011) in a meta-analytic review of the predictors of offender treatment attrition literature identified 114 studies which represented 41,438 offenders. They reported that low cognitive–academic ability does not bode well for the successful completion of programmes that draw heavily on verbal skills, written homework assignments, or cognitive interventions. They also argue that programmes must be specifically adapted in terms of content and delivery for low functioning clients.

In summary therefore, in order to adhere to the principle of general responsivity, CBT treatment approaches appear to be the most effective. But within a CBT approach, adaptations for

ID individuals must be made to accommodate their characteristics, learning styles, and needs. The process of adaptation of mainstream CBT methods is advocated by those working with ID populations (e.g. Lindsay, Mitchie, Steptoe, Moore and Haut, 2011).

4.5 Adapting CBT for IDSOs

Cognitive behavioural interventions with sexual offenders commonly utilise the Relapse Prevention model (Pithers, Marques, Gibat, and Marlatt, 1983). The Relapse Prevention model (RP) is a self-management approach to treatment. It assumes that offending behaviour is not committed on impulse alone, rather it usually involves a build up of risk factors which can be identified and addressed. The RP approach seeks to ensure that offenders acquire coping skills to manage their risk factors and thereby lessen their likelihood of reoffending.

Haaven and Shlank (2001) noted that, although the CBT models of relapse prevention described in the literature for non ID men were in the most part compatible for ID sexual offenders, there have been some problems in relation to the application of the models. More specifically, they outlined that IDSOs may have more difficulty recognising some risk factors, especially those related to controlling affective responses. They also highlighted various factors which must be attended to in treatment. For example, the need for support systems to assist this client group with their management of risk and relapse. They also reported on the importance of developing self efficacy skills with this client group. They describe the need to develop and foster a success identity. They suggest that this client group often have low self esteem and self worth. It is therefore important that goals are developed to achieve a distinct and unique identity. This sense of self will in turn increase their efforts to succeed and meet their expectations (Haaven and Coleman, 2000).

Taking these factors into account Haaven and Shlank developed the Old Me/ New Me model as described in Haaven (2006a). When using the Old Me/ New Me model, IDSOs are encouraged to begin by identifying their New Me goals (the person that they want to become and the life they

want to live). The clients associate the term of New Me with their new sense of self-identity. This gives the client the sense of becoming a “somebody” (Haaven and Coleman, 2000). The “new me” label constitutes a strengths based focus to the rehabilitation process.

There is considerable literature that suggests that those with ID are significantly likely to be exposed to chronic negative social judgment and discrimination (Dagnan and Jahoda, 2006). They do recognize the social disadvantage and stigmatization that they experience on a daily basis (Reiss and Benson, 1984). They recognize that they are treated differently. This is a particular source of stress (Lunsky and Benson, 2001). This stigmatization and the corresponding effect on their self identity is reinforced by their being segregated from non-developmentally disabled persons, having fewer employment opportunities, marrying less and having less satisfying social relationships (Dagnan and Jahoda, 2006). Haaven (2006b) suggests that the attention given to developing a new, personalised, positive identity in the Old Me/New Me model may be why many clients seem motivated for change using this model.

Using this model offenders also have to identify the characteristics of Old Me. These are the thoughts feelings and behaviours which contributed to offending. The terms Old Me and New Me are useful labels that can be used throughout treatment. The next step in the process is encouraging the group members to consider how life imbalance can lead to offending behaviour.

In conclusion, the Old Me New Me model as outlined by Haaven and colleagues has been specifically designed as a CBT treatment approach for IDSOs. It has been widely used by clinicians with ID sexual offenders in other correctional settings, including in the United States, Canada, Australia and New Zealand. Practitioners working with this client group report the usefulness of this approach. However, only one study has attempted to evaluate the success of the model against other treatment techniques. Mann *et al.*, (2004) compared Old Me/New Me with traditional relapse prevention procedures in a sample of non ID sexual offenders. The authors

concluded that the Old Me/ New Me techniques led to equally clear knowledge of risk factors coupled with more engagement and participation in the process of change.

It can be concluded therefore that Old Me/ New Me provides a useful model for relapse prevention work with IDSOs and as such ensures that the treatment approach is developed in adherence with the general responsivity principle. Yet, individuals with lower IQ are not a homogenous group. The importance of adapting treatment delivery to meet the needs of this group has been widely documented. Various practitioners have outlined strategies for enabling learning in this client group which have been helpfully summarised by Hurley, DesNoyers, Daniel, and Pfadt, (1998). They recommend that the following adaptations are made when developing CBT approaches for use with ID individuals; simplification of treatment concepts; consideration of language use; need to include multi modal activities; targetting treatment at the developmental level of the individual; use of directive flexible methods; involvement of caregivers in treatment; consideration of transference/ counter transference issues, and paying attention to wider rehabilitation approaches.

In conclusion, CBT approaches must be designed to meet the specific needs of this client group. That is, the approach must be adapted so that it is generally responsive for those with intellectual disabilities. The Old Me/ New Me framework provides a method for enabling this. Further, each individual in treatment will have a range of strengths and needs and as such, treatment must be designed and delivered in a responsive way so that it is personally relevant to each person in treatment.

4.6 Group environment

Decision making about how treatment is offered, i.e. individually or in a group, is usually based on practical or financial reasons. There is little research which points to the best approach. Clinicians suggest that group treatment is likely to be more effective with sexual offenders than

individual treatment as it provides a greater range of potential learning opportunities; providing multiple sources of challenge and support from different perspectives, increased options for vicarious learning, and an increased ability to acquire and rehearse interpersonal and relationship, self-, and affect-regulation skills (Ware, 2009).

The literature outlines two studies which have looked at the factors affecting the group environment in sex offender treatment. Beech and Scott Fordham (1997) used the group environment scale (GES) to assess the following components of group processes; relationships in the group, personal growth of the group members and group structure. The GES was administered to leaders and participants of various probation led sex offender groups. Results suggested that there were a relationship between atmosphere in group and treatment change. Successful groups had a sense of hope in the group members, cohesion amongst the group members, good organisation, desirable group norms and good leadership. Beech and Hamilton- Giachritsis (2005) examined whether the group environment was related to changes in pro offending attitudes within groups. They found that significant treatment change on measures relating to victim empathy, cognitive distortions and emotional identification with children were associated with levels of cohesiveness in the group and the extent that the group members felt able and encouraged to express themselves.

There is no specific literature relating to IDSOs and the group environment factor. However, given the difficulties associated with ID, such as poor social and communication skills, it is hypothesised that group process issues and dynamics may be particularly important for IDSOs. Certainly it seems that the fact that treatment is offered in a group has affected decision making to attend treatment. Rose, Jenkins, O'Connor, Jones and Felce (2002) reported that IDSOs were hesitant to attend treatment groups.

Another factor relevant to the group environment is the type of the group itself. Open-ended (rolling) groups are different from closed-groups in that offenders within the group do not start treatment at the same time, although they will complete the same treatment content. There are, then, a number of offenders within a treatment group at different stages of their treatment. Ware, Mann, and Wakeling (2009) in a review of the available research concluded that both group formats were similarly effective. The advantage of open-ended groups tend to be practical given that open groups help prevent long waiting lists for treatment places. There does not appear to have been any research investigating the relative merits and effectiveness of open-ended (rolling) versus closed-group formats when treating sexual offenders. Further, it is not clear whether open-ended groups would be effective with certain types of sexual offenders, i.e., individuals with ID.

In summary, the group environment may be an important responsivity factor in treatment success for sexual offenders. Yet, there is a dearth of studies which address key variables in relation to treatment delivery. The effectiveness of a group based approach remains largely unknown although most correctional services use group treatment with sexual offenders. A recent systematic review however, shows better effects for programmes with some degree of individualisation (Lösel and Schmucker, 2005).

There is an absence of studies concerning group environment with ID individuals. We do know that sexual offenders benefit best from group treatment programmes that are specifically adapted in content or delivery to suit these types of needs (e.g., Keeling Rose, and Beech, 2006). Coleman and Haaven (2001) and Rose et al., (2002) noted that group treatment is the treatment choice for ID sexual offenders. They suggest that group size is usually smaller, 6 rather than 8 group members which is standard for non IDSO groups. They noted that the power of the group is its ability to both support and confront the group member. Coleman and Haaven (1998) comment on the need to foster a sense of “groupness” and culture among clients. As such, it appears that a closed group format may be best suited to this client group. There is no literature relating to treatment

effectiveness for mixed groups although Williams *et al.*, (2007) found that both child molesters and rapists achieved success on ASOTP.

In conclusion, group environment and process may be important responsivity factors in the treatment of sexual offenders. The literature pertaining to IDSOs is sparse, but it seems there is some support for closed group formats to enhance group cohesion.

4.7 Therapist characteristics.

Andrews and Bonta (2006) outline the importance of the therapist in treatment, stating that it is not so much the adoption of a CBT approach that produces effectiveness, but rather whether or not therapists are carefully selected for, and trained in, the appropriate skills. These skills include: empathy, warmth, respect, interest, and non blaming communication. Andrew and Dowden (2007) further define what is important in relation to therapist characteristics: “High-quality relationships are characterized by respect, understanding, care, and positive expectations. High-quality structuring skills include pro-social modelling, effective reinforcement, effective disapproval, and the effective use of authority, advocacy/brokerage, and skill-building with reference to problem solving and self management, cognitive restructuring, and motivational interviewing skills. Counsellors, therapists, and some correctional professionals need to be very talented and experienced in this array of skills” (p457). The importance of this responsivity factor is outlined in Dowden and Andrews (2003) who demonstrated that when programmes met the standards outlined in terms of therapist style and training criteria, the treatment effect size was significant ($ES = .39$) whereas when these criteria were not met there were essentially no benefits from treatment ($ES = .04$). The importance of the therapist’s influence on treatment outcome has been usefully summarised by Kozar, (2010): “Successful programme delivery requires enacting the right action at the right time to respond to both individual and group needs. Not only is knowledge of offenders and offending essential, but each therapist has to develop his or her own principles of programme delivery based on training, experience, supervision and organisational practices. This skill and

knowledge base in tandem with personal values and attitudes will inform a conceptualisation of how clients can be assisted to change” (p207).

This importance is not new, nor is it specific to forensic or criminal settings. Sternlicht (1965) noted that: “it seems not unlikely that the success of any therapeutic or rehabilitative endeavour may be mainly the result of the sense of importance that a patient feels when an intact stranger is sufficiently concerned with him to spend time and effort for the patient’s benefit” (p86). Yet, the literature base in this area relating to outcome in sex offender treatment is small, and for IDSOs it is non-existent. The studies which have been undertaken in this area are described below.

In 1997, Beech and Scott Fordham utilised the Group Environment Scale (GES), (Moos, 1986), referred to previously to examine the experiences of sex offenders in treatment. Their study examined twelve sexual offender treatment groups, eight of which took place in community settings, and four in a long term residential treatment facility, all in the United Kingdom. They found a range of treatment climates across these groups, particularly in terms of cohesion, expressiveness, independence, task orientation, anger/aggression, and order/organisation. They were then able to identify the success of each group in terms of bringing about clinical change in their members. The most successful group in their study rated highly on cohesion, leader support, independence and order/organisation, and had a low rating on leader control. The least successful group showed negative ratings on cohesion, independence, and leader support, and a high rating on leader control. Based on these data, Beech and Scott Fordham concluded that successful sex offender group leaders should “set a clear structure and set of rules for the group, they should not be aggressively confrontational, but be supportive and model effective interpersonal interactions... Leaders should be aware that if the group experience is too confrontational, members’ ability to benefit will be impaired” (Beech and Scott Fordham, 1997, p234).

However, the studies described have focused exclusively on self report data. A more robust investigation was undertaken by Fernandez (1999). In this study, videotapes of HM Prison Service sex offender groups were studied and rating scales were developed to measure therapist techniques and therapist style. Ratings were then related to clinical change measured by pre- and post-treatment psychometric testing, and also to in-session behaviours by the group members. The therapist techniques measured were centred around three core skills: encouraging active participation, non-confrontational challenge, and use of open questions. Aspects of therapist style measured included warmth, empathy, genuineness, hostility, coldness and deception. Dependent variables in this study were in-session behaviours by clients, such as level of participation in the treatment sessions and verbalisations indicating that clients took responsibility for their offending behaviour. Psychometric measures of perspective-taking, acceptance of future risk, knowledge of coping strategies, and self-esteem were also examined. Fernandez found that taking responsibility by clients was linked to warm, empathic and genuine behaviours by therapists. Group participation increased when therapists actively encouraged participation, used open questions, and challenged in a non-confrontational way. Improvements in perspective-taking were related to encouragement by therapists to participate and sincerity on the part of therapists. Acceptance of future risk was related to non-confrontational challenge and warmth/empathy/genuineness. Lastly, improvements in coping skills were related to the use of open questions by therapists. There was no relationship between changes in self esteem and therapist behaviour.

Lopez - Viets, Walker and Miller (2002) also considered that the role of the therapist is to encourage firstly the individual to recognise that their behaviour constitutes a problem through cognitive dissonance. Secondly, to assist the client to regard positive change to be in their best interests, and foster a sense of hope so that the individual feels able to change, develops a plan for change, and starts to take action using strategies that discourage a return to the problem behaviour (Miller and Rollnick, 1991).

Marshall *et al.*, (2003) confirmed the idea that behaviour of the therapist in sex offender treatment influences the way in which clients benefit. Beneficial changes in relation to coping skills were seen via both open ended and directive question asking. The authors conclude that this is part of the wider influence of flexibility as a key therapist feature. The importance of an empathic, warm, and rewarding style is also described. Other beneficial features include using appropriate body language, appropriate use of speech, and encouraging participation.

Drapeau (2005) found that sexual offenders judged the role of the therapist to be crucial to any benefits they derived from treatment. While clients believed some of the techniques were valuable, the therapist was seen as the most important factor. Effective therapists were viewed by sexual offenders as honest and respectful, caring, non-critical, and non-judgmental. Confrontation in therapy led clients to withdraw from effective participation, while therapists who worked collaboratively with the offenders elicited their full engagement.

One of the assumptions often made about CBT for people with intellectual disabilities is that due to their communicative and cognitive deficits a more didactic therapeutic approach is required, with the emphasis on the role of the therapist as instructor (Willner, 2005). In contrast, this study demonstrates the importance of communication as a mutual process, in terms of maintaining a dialogue on a therapeutic topic. Whilst the therapist may feel more purposeful to have a clearly defined teaching remit, the material is only going to be meaningful if the client demonstrates a grasp of what is being said and understands its relevance to them. Hence, there may be a greater need for the negotiation of meaning and encouraging the active involvement of clients when they struggle with comprehension and communication.

The impact of the therapist on client dropout has previously been reported (Luborsky *et al.*, 1985). Confrontational and directive styles are ineffective in producing lasting behaviour change. Such styles are more likely to result in client resistance and in turn poorer treatment outcomes.

This is because such styles induce the client/offender to protect their self-image via resistance and disagreement. Thus facilitator style is likely to have a larger effect on outcomes than either specific treatment approach or client characteristics. Clinician/facilitator characteristics associated with treatment effectiveness for substance users include establishing a helping alliance and good interpersonal skills. These were more important than professional training or experience (Najavits and Weiss, 1994). Thus Miller and Rollnick (1991) emphasise the importance of clinicians having a client-centred, supportive, and empathic style that uses reflective listening and gentle persuasion.

Mann (2000, 2001) concluded that therapist style should be characterized by positive attitude to clients, a self-evaluating approach to the provision of therapy, an inquiring mind and a warm interpersonal style. The implications of these findings are significant to this research. The fundamental pre-requisite of empathy, respect and care towards individuals who have caused untold harm to often vulnerable members of society, in order to reflect meaningful change, may require facilitators to manage a range of their own conflicting emotions. Add to this the skills and competencies required for this work, and it becomes easier to see that the role of therapist in sex offender treatment is particularly demanding. Although there has been no empirical work specifically on the effect of therapist style on IDSO behaviour, it is to be expected that the effects already noted in the work concerning sex offenders in general will also be present, possibly with even stronger relationships. This is because IDSOs are not only subject to the same societal negative sanctions and serious stigmatisation because of their crime, but they will probably have long suffered negative societal attitudes because of their disability.

4.8 Treatment context

Ware (2009) in a review of the contextual factors surrounding sex offender treatment argued that contextual factors in treatment may be important to the overall effectiveness of treatment. To date, these contextual considerations have not been reported as general responsivity factors, but given that they have a clear role to play in treatment outcome, they are considered as such within

this literature review. Gendreau, Goggin and Smith (2001) state, 'It is ironic that the fundamental concept in the delivery of effective offender treatment services, that of program implementation, has traditionally received the least attention" (p247). Andrews and Dowden (2005) reflected that indicators of programme integrity are rarely reported in the literature despite the contribution they make to enhance the potential impact of offender rehabilitation programmes.

Treatment setting: Community-based programmes reveal larger effects than prison-based interventions (Andrews and Bonta, 2010; Koehler, Lösel, Akoensi, and Humphries, 2011; Lipsey and Cullen, 2007; Schmucker and Lösel, 2009). The reasons for this difference are not fully known. Losel (2012) postulates that this may be due to 'deviancy training' in prisons, or related to difficulties with the transfer of learned material to the wider world, or due to difficulties during resettlement. Losel suggests over interpretation of this finding should be avoided as most evaluation studies comprise comparisons with same-setting control groups and not between custodial and community settings.

When considering the impact of treatment setting, attention should be paid to the transition of offenders through the Criminal Justice System. The setting in which treatment takes place should not be isolated from the individuals wider progression through the criminal justice system. Institutional programme effects depend on appropriate throughcare, aftercare and relapse prevention measures (Farrall and Calverly, 2006; Maguire and Raynor, 2006). Wormith *et al.*, (2007) outline the suggested factors that must be addressed to enable effective offender resettlement. These include using more careful empirically based risk assessment procedures, careful screening of offenders with mental health problems, more prison based educational and vocational training programmes to teach marketable job skills, more vocational and work programmes to develop good work habits and better discharge planning activities and meaningful community linkages to make services immediately available on release. They observed that vulnerable prisoners tend to "fall through the cracks" when services are interrupted, therapeutic

alliances are disrupted and agencies spend their time duplicating data gathering and treatment activities (Lurigio, Rollins and Fallon, 2004). Although these authors are describing their working experiences in the US, the same problems have historically applied to correctional services in the UK.

Coleman and Haaven (1998) when describing the requirements for interventions with ID sexual offenders, talk about designing a “service continuum.” They highlight the importance of paying attention to “maintenance issues” in treatment design. They state that “intellectually disabled sexual offenders are more in need of transitional services than nondisabled offenders. Easily overwhelmed by change in structure, the intellectually disabled sex offender is more likely to regress to previous patterns of dysfunctional and inappropriate behaviour. Any change can be threatening and generalization is more difficult” (p283). The authors noted that without planning the ID sexual offender is vulnerable to relapse.

Haaven and Schlank (2001) suggested that ID sexual offenders have additional problems when it comes to generalising their newly learned skills to the community setting. Haaven (2006a) suggested that clients experiencing stress are more likely to use coping strategies effectively if they have a large network of nurturing environmental contacts and are therefore less insulated from their environment. One of the variables assumed with the probability of offending with this population is the degree of isolation perceived by the offender (Griffiths, Hingsburger and Christian, 1985; Haaven *et al.*, 1990).

Haaven and Schlank also suggested that the level of support required for an ID sexual offender is greater than for a non ID sexual offender. Developing and maintaining healthy support systems is an important part of offender management with ID offenders in the community, in order to assist them in achieving a non-offending lifestyle. The offenders may have vulnerabilities that limit their ability to self-manage their behaviour so they need to be provided with support around high-risk

situations and assistance with risk-management strategies. By doing so the authors argued that the effectiveness and safety of the ID offender's transition into the community will be increased. Forrester- Jones *et al.*, (2006) described social networks as "opportunity structures" for a range of relationships. They suggested that social support may be derived from different sources, both informal (family, friends, neighbours) and formal (paid carers). The authors described the importance of social relationships in relation to happiness, self esteem and confidence, mental health and leisure activities.

In conclusion, treatment developers must pay attention to treatment setting and encourage "through the gate" provision. The specific needs of ID sexual offenders mean that such provision is especially important. This group are likely to be particularly sensitive and vulnerable as they progress from Prison into the community. They cope poorly with change and so may become at greater risk of reoffending if their transition through the Prison and Probation systems is not managed well.

Organisational considerations: There are a number of organisational considerations that are important in programme design within correctional services. If the organisation is not committed to the programme integrity, even the most highly trained, highly skilled practitioners will have little impact (Roberts 1995; Hollin, 1995). Bonta (1997) emphasised that in order to implement effective programmes it is essential that the organisation accepts the value of rehabilitation, communicates this value to staff, and provides the necessary support for delivering the services. It is vital that strong communication networks are running before the implementation begins as this ensures that the relevant information gets to the people that it concerns. Leschied *et al.*, (2001) noted that a major challenge in correctional services is to find innovative ways to communicate what is known in order to support implementation and specifically to make available to all levels of staff the increasing knowledge in this area.

Gendreau (1999) identified the need for a senior advocate in an organisation who is willing to champion the cause of a programme as an essential ingredient in the effective implementation of programmes. Serin and Preston (2001) also emphasised the need for the designation of a corporate champion who is reasonably senior, well respected and passionate about a programme. At the site level, they reported the need to market programmes in the organisation and the need to integrate the programme successfully into the existing culture, structure and routine of the institution. They reflected that programme staff must establish professional and personal credibility with other staff and offenders. Palmer and Hollin (2004) highlighted the importance of the role of the programme leader. They noted that the experience from several psychosocial programmes indicated that programmes often die when their innovators move on and that the leader needs to have a variety of skills, as well as having a high level of expertise in the area of offender treatment. In addition, they need to be an effective manager and work within the demands of the specific organisation within which the programme is implemented. The above authors all highlight the importance of having a programme 'champion', this role is likely to be needed at all levels of the organisation including site, area, regional and national levels. However, the evidence reported is based on practitioner observation and experience, and there have been no research studies addressing these issues to support (or refute) these assertions. Further research in this area is warranted.

The impact of social climate within the organisation was first outlined by Moos and Houts (1968) who suggested that the social climate would have important influences on the behaviour of patients and staff in institutional settings. The importance of mutual respect, humanity, support, relationship-orientation and trust have been outlined in relation to the prevention of conflicts, suicides and other problems (Liebling and Arnold, 2002). Raynor and Vanstone (2001) and Serin and Preston (2001) also noted the importance of the organisational climate in which the programme is

implemented as well as the need for belief and commitment to evidence-based practice, an ability to influence, and the need for support of all the stakeholders.

Olver, Wormith and Stockdale (2011) also noted the importance of organisational climate in relation to treatment completion. They noted the importance of both the treatment and the “other facility staff” suggesting that “it is these individuals who are often the final arbiters in a decision for a client to leave treatment early” (p16). They stress the importance of all staff working to engage and support high risk and need clients in treatment “at the very least it is incumbent upon staff to stay aligned, to expect and accept difficult interpersonal behaviours (e.g., hostile, disruptive, or manipulative behaviour) from these clients, and to monitor their own counter transference reactions” (p16).

The impact of organisational climate is deemed to be significant in relation to treatment outcome with those with ID (Langdon, Swift and Budd, 2006). There has been limited applicability of this concept in relation to the social climate of those with ID in forensic settings. Haaven and Shlank, (2001) described the importance of the treatment environment. They suggested that it must be supportive and suggest to the ID sexual offender that he is in a safe place which is respectful and humane (Ferguson and Haaven, 1990). Haaven and Shlank noted that ID sexual offenders are particularly sensitive to their surroundings and physical environment. They noted the importance of the physical environment and suggested “Most importantly, a culture in which status is gained by participation in the programme needs to be nurtured and a sense of responsible self identity encouraged” (Haaven and Coleman, 2000, p281).

Staff training and support: Even the best designed treatment programme can have a negative effect if the quality of the delivery is poor (Leschied *et al.*, 2001). No training or treatment materials can be expected to be effective if there is an absence of trained and committed staff with adequate resources and managerial support. Roberts (1995) argued that practitioners must have a sound

basic education and training in the range of theory, skills and competencies that are required to deliver effective programmes.

Rex *et al.*, (2004) carried out an evaluation of seven community service pathfinder projects. They noted the following factors which seemed to facilitate effective implementation; staff commitment, staff understanding of the aims of the project, amount of support provided by the managers and colleagues, effective teamwork and adequate preparation for the organisational/structural change process through communication, support and training.

The authors found that some staff felt that they were not involved in the process from the beginning and this led to them feeling unprepared. This highlights the importance of communication, commitment, training and support throughout the whole process. It is vital that staff feel they are involved to strengthen their commitment.

A number of researchers have noted that the training of staff involved in programmes is pivotal (Leschied, 2001; Fixsen *et al.*, 2001; and Raynor and Vanstone, 2001). Serin and Preston (2001) argued that the single most important factor contributing to the successful implementation of any programme is staff selection and training. Alongside this is the need to provide support feedback and supervision to programme staff (Palmer and Hollin, 2004).

Andrews and Dowden (2005) recommended, as a result of their meta-analytic study regarding programme integrity, that the programme manager should support the delivery by selecting staff on relevant skills and ensuring relevant training and clinical supervision by trained supervisors.

Lipsey and Wilson (1998) found that programme monitoring by the researcher resulted in larger treatment effects. Andrews and Dowden (2005) conducted a meta-analysis to examine issues of programme integrity and their impact on recidivism reduction. They found that 'involved researchers' take reasonable steps to ensure higher levels of programme integrity and are not a

source of bias. They recommended specifically that they are involved in monitoring treatment process and intermediate change on targeted criminogenic needs. There is no specific literature relating staff training and support to treatment outcome with IDSOs. Suffice to say that the importance is likely to be as significant with this client group as it is with non IDSOs.

Treatment intensity: Little has been written about the intensity of treatment required to produce significant changes. There appears to be an apparent lack of research in this area, not only in the field of sex offender treatment, but also in relation to the treatment of ID more widely. Warren, Fey and Yoder (2007) in a review of the literature in relation to intervention techniques designed to enhance the communication and language development of children with ID, commented that “there is very little literature on this topic for any domain of development” (p70). The authors point out how different this is to “when a therapeutic drug is developed, systematic research is virtually always conducted on its effects at different dosages... in part to determine side effects and safety of new drugs, but an equally important reason is to estimate the therapeutic effects of different dosages.”

Notwithstanding the limitations in the literature, we are reminded that Hanson and Bussiere (1996) found that length of treatment did not correlate with reduced reoffence rates. This data included men with ID and so it is hypothesised that this finding is also applicable to ID sexual offenders (Blasingame, 2005). In Hanson and Morton-Bourgon’s (2004) meta analysis this finding was also supported. Despite these findings, the length of treatment with ID sexual offenders groups has been reported to bear significance on subsequent recidivism. The most common adaptation to treatment in recognition of developmental needs relates to length of treatment. Unfortunately the detail about treatment length in terms of dose or intensity of dose is often missing from the descriptions in the literature. Lindsay (2002) concludes that, while there was no empirical evidence of the dose required for a reduction in reconvictions, it appeared that intellectually disabled men generally needed longer in treatment to achieve treatment targets. Due

to the lack of detail about treatment dosage and intensity, caution is advised against the over interpretation of this data.

Other researchers have focused on treatment length according to risk classification. Boer, Tough and Haaven (2004) described adapting treatment and supervision length and intensity according to risk of recidivism. Beech et al (1999) found that low risk sexual offenders seemed to do as well with a short, 80-hour programme as with a longer 180 hour programme. However, Friendship, Mann and Beech (2003) found that 180 hours of treatment was insufficient for high risk men and have subsequently recommended a dose of about 300 hours for the riskier offenders (Mann and Fernandez, 2006). There is no equivalent research on treatment length and risk classification in the treatment of IDSOs.

4.9 Concluding comments

In conclusion, there is a body of literature which has examined various general responsivity factors in relation to their reported outcome or treatment success. These factors go beyond what was originally defined by Andrews and Bonta as general responsivity. Four general responsivity factors have been identified. These factors are external to the individual and are fundamental to the success of treatment. Broadly speaking they relate to the treatment approach, group environment, therapist characteristics and treatment context. Yet, given the recognised importance of these factors, there remains a lack of understanding about the role of these factors in treatment, especially in relation to the treatment of IDSOs. As such, it is important to consider the evidence from the process evaluation literature. There is a body of literature which pertains to the experience of treatment from the participant's perspective. Clients' perceptions of treatment and of the therapist (Heppner and Clairborn, 1989) have been demonstrated to significantly influence compliance with treatment as well as treatment success. Moreover, it is particularly important when working therapeutically with clients to listen to their experience of the treatment

process. Yet, limited research has been conducted to describe the participants experience of treatment.

4.10 The general responsivity factors; a review of the treatment participant experiences literature

In this section a review of the process evaluation literature pertaining to participant's treatment experience is provided. Firstly, the literature relating to the experiences of sexual offenders in treatment will be outlined, and secondly, the literature relating to those with intellectual disabilities will be described.

Experiences of sexual offender participants in treatment: There have been few studies investigating the experiences of sexual offenders in treatment. Garret *et al.*, (2003) found that sexual offenders generally have a positive view of treatment, and especially the group process. Pribyl (1998) examined child sexual offenders' views of the treatment they received. Significant themes to emerge were the 'increased awareness of the connection between thoughts, feelings and behaviours', 'the fear of consequences', and 'victim empathy'. There were also significant factors, which were found to interfere with successful treatment, including perceived negative therapeutic/therapist qualities. Martin (1996) explored the experiences of men as they went through an offender treatment programme. Key themes were the importance of being supported by others, working hard to stay on track, contending 'rough spots', and being transformed by the 'journey'. Day (1999) reported that clients generally viewed their treatment favourably. They appreciated structure to the treatment and found the most helpful aspect was the support they felt. In previous studies which served to evaluate the non ID sex offender treatment programme within HM Prison Service, Beech *et al.*, (1998) reported that 76% of participants found the treatment programme "very helpful." A further 20% reported that it "helped quite a lot." The authors noted that this was promising as they hypothesised that men who regard treatment positively are more likely to internalise treatment messages and remain motivated.

Wakeling, Webster and Mann (2005) examined the experiences of 46 men who had completed HM Prison Service Core programme using both quantitative and qualitative approaches. They found that generally participants found the programme to be a positive experience, suggesting that they gained in relation to self development, positiveness for the future, understanding of the offence, victim empathy, coping strategies and an awareness of others. They also reported on various helpful aspects of treatment related to process, for example, having good tutors, good group dynamics and realising that you are not alone. Unhelpful aspects of the programme judged to impede treatment success included; groups being too large, cultural difficulties and cancelled sessions. Some also reported that they had experienced poor support or poor group process.

Experiences of intellectually disabled participants in treatment: There is very little research into the views of IDSOs, and the work that has been undertaken has largely focused on their experiences of their environment, and not specifically on their experience of treatment. For example, Flynn and Bernard (1999) describe a study of 20 offenders (16 male and 4 female) with ID, some of whom had engaged in sexually abusive behaviour. In describing their experiences of the criminal justice system in medium and high security services in the UK, they identified generally negative experiences, including difficulties in understanding what was happening, feelings of anxiety and stress both before and during the court process, and fears of being locked up. Participants reported many negative aspects of prison, high security services and medium security services (e.g., victimisation by prison officers and inmates, bullying, assaults, and rigid treatment regimes), but also some positive views (e.g., having regular meals, having a private cell, access to therapy, and work opportunities).

Murphy *et al.* (1995) followed up 26 people with ID (all of whom had a history of offending behaviour, but not all of whom had been convicted) following their discharge from a low security service in London. The majority described positive aspects of the care they had received, including staff generally being interested in and concerned about them, enjoying engaging in leisure

activities, and the service providing a relaxed and friendly atmosphere. While most were positive about the therapeutic options offered to them, a number disliked talking about their past, were sad about being in hospital, and angry when physical restraint was used.

Macdonald, Sinason and Hollin (2003) used Interpretative Phenomenological Analysis to analyse results from focus group discussions with learning disabled offenders about their experience of group psychotherapy. Both positive and negative views were suggested. On the positive side participants spoke about how the group had provided them with a context in which they felt able to talk and share difficult experiences. They reported feeling valued in the group, which was contrasted to their more usual feelings of exclusion. All participants found therapists to be valuing, encouraging and helpful. Macdonald *et al.*, note that the warmth and acceptance that the participants received in therapy was often contrasted with their “normal” experience of rejection within social contexts. The authors noted that the group may provide participants with a relatively unfamiliar experience of acceptance and validation. Whilst these processes are consistent with this type of work with non learning disabled populations, these processes may be particularly important for people with learning disabilities “who are likely to have more difficulty being listened to and being accepted due to their disabilities and the stigma and abuse they are likely to have suffered” (p446). The negative comments about the group included denying that the group therapy had had an impact. The authors concluded that these comments serve as a reminder that any work with this client group is likely to need to be long term. The negative elements of participant’s experience of group psychotherapy suggest that some group members found it painful. They talked of boredom in treatment and problems with other group members, or group members leaving treatment. They talked about emotional pain of having to share painful experiences. The other cluster of negative views related to negative characteristics of the other group members and the stigma that being associated with them brought them. Confrontational

therapists were also poorly regarded. Various other problems were also described by participants e.g. noise outside the group room, no tea and biscuits at break, sleeping during the group.

Hays, Murphy, Langdon, Rose and Reed (2007) described the self reported experiences of 16 men with ID and sexually abusive behaviour following completion of a year long cognitive behavioural group for sexual offending. The authors developed a "Service User Interview" to access the participants' views and understanding in relation to 3 broad areas: (i) Factual/memory-related questions designed to check participant-recalled basic aspects of the group, (ii) Content questions concerning the material covered during the group treatment programme, and (iii) Views of treatment questions requesting the participant's views on the group. Results suggested that the most salient components of treatment recalled by participants were: sex education; legal and illegal behaviours and their consequences; and discussions about specific sexual assaults. Only 3 of the 16 participants stated that they had problems with sexual offending, and only 1 identified that he had learnt about victim empathy, although this is described by the authors as an important component of treatment. Having support, the knowledge that they had the same problems as other group members, and talking through problems, were appreciated as some of the "best things" about the group, while the "worst things" were generally person-specific. Participants had mixed views about describing their offending behaviour in treatment. They viewed the experience as difficult but helpful. Location of group and the timing of group were also cited as negative factors which group members commented on. Evening sessions were unpopular and dissatisfaction was expressed at having to travel a long way to get to treatment. Another negative factor related to fears over confidentiality because a group member was in treatment with someone with whom he lived. A factor which was perceived both positively by some and negatively by others was the group finishing. Thirty eight per cent of the men (6 of 22), said the best thing about treatment was the group finishing (along with the coffee breaks), whilst 2 men said the worse thing about treatment was the group finishing and that they wanted it to continue.

In conclusion, the literature which describes treatment experience from the perspective of the treatment participant reveals a number of positive and negative aspects to treatment which help our understanding of the general responsivity principle. These factors map onto the general responsivity factors which have been identified in the treatment outcome literature and have been summarised in table 4.1 below.

Table 4. 1

General Responsivity Factors

General responsivity factor	Positive aspect	Negative aspect
The treatment approach	Finding treatment concepts helpful; being listened to and understood; feeling valued, contending the “rough spots” to enable the treatment “journey”	Denying treatment had any impact/ finding treatment boring;
Group environment	Supportive group; Being able to help others; Realising you are not alone	Poor group mix; Changes in group membership; Groups being too large; Emotional pain/ difficulties talking and listening to others; Stigma associated with the perceived negative characteristics of other group members
Therapist characteristics	Having good/ helpful/ supportive/ valuing facilitators;	Confrontational therapists
Treatment context	Staff support, concern and care Having access to therapy	Cancelled sessions; Cultural difficulties; timing of the group, location of the group; noise outside the group room, no tea and biscuits at break, sleeping during the group; Concern about treatment ending

4.11 Responsivity factors from the therapists perspective; a review of the treatment experience literature.

Both the treatment outcome and process evaluation literature highlighted the importance of the therapist in treatment. Indeed, in their discussion of the general responsivity principle, Andrews and Bonta (2006) suggest that the therapist’s role is more important than any of the other responsivity factors. We know that the therapist’s style (their warmth, empathy and genuine interest) and their overall competence (as demonstrated by their knowledge understanding and

skills) relate to treatment success. The responsivity factors relating to treatment success have always been reported through the eyes of the treatment participants. Therapists are crucial to the success of treatment, and as such it is important that any responsivity factors which may affect their approach to, or facilitation of, treatment are controlled for by the treatment design process, and managed during the course of treatment. The body of research which describes the treatment experience for treatment therapists has therefore been reviewed. This literature identifies a range of responsivity factors for therapists involved in treatment which are described below.

The therapist treatment experience literature reports on the psychological impact of treatment on providers in general. There are a small number of studies which focus on forensic issues and some studies which explore the impact of working with sexual offenders. There is also a small body of work which describes the impact of working with those who have intellectual disabilities. There are very few studies which look at the specific impact of working with intellectually disabled sexual offenders. Studies pertaining to working with sexual offenders are outlined first, and subsequently, studies pertaining to working with intellectually disabled individuals and IDSOs are described.

Therapist experiences of working with sexual offenders: Historically, the literature pertaining to the experiences of working with sexual offenders has focused on the detrimental effects to therapists (Ryan and Lane, 1991). One outcome is that studies consistently indicate that between one-fifth and one quarter of participants report deleterious psychological changes that they attribute directly to their work with sex offenders (e.g. Edmunds, 1997; Farrenkopf, 1992; Myers, 1995; Turner, 1992). Yet, more recent research has highlighted the fact that therapists do not only experience negative feelings as a result of their work with sex offenders. The work can also lead to major positive experiences. Both the negative and the positive experiences will be explored in this chapter.

Working with sexual offenders; the negative experiences: Moulden and Firestone (2010) noted that “in recent years there has been a proliferation of research addressing the occupational hazards associated with psychotherapy...” (p 374) Pope and Tabachnick (1993) reported that 80% of therapists experience negative feelings, such as fear, anger, and sexual feelings, within the context of the therapy they provide. These negative feelings have also been widely reported by clinicians working with sex offenders (Ryan and Lane, 1991). And Sheehy and Friedlander (2009) have suggested that some level of work related distress will be observed within nearly all sex offender therapists.

As such, the literature relating to the experience of therapists working in sex offender treatment is heavily negatively influenced. Farrenkopf’s (1992) study is recognised as the first to investigate the personal impact on clinicians of working with sexual offenders (Ellerby, 1997). Specialist therapists reported mainly negative effects. More than half (54%) the respondents believed they had adopted a more cynical, less optimistic outlook since working with sexual offenders. Negative emotional impact (including dulled emotions) was reported by 42% of respondents and anger and frustration with clients overflowed into social domains. Women, in particular, disclosed feelings of hyper vigilance, suspicion and self-protection. Farrenkopf (1992) reported evidence of burnout, particularly in long-service clinicians, with disclosures of exhaustion, high stress and depression (25%), leading occasionally to termination of sexual offender work. This pattern of responses to treatment was echoed by Edmunds (1997) who identified fatigue and frustration, cynicism, sleep disturbances, general irritability, difficulty making decisions, depression and/or depressive episodes.

Mental health professionals attending the Association for the Treatment of Sexual Abusers (ATSA) conference (1993) reported experiencing painful and disturbing intrusive visual imagery about sexual violence, changes in their own sexual behaviour and fear for their own safety as a result of working with sex offenders (Jackson, Holzman, Barnard, and Paradis, 1997).

Research into the impact of treatment on staff delivering the HM Prison Service sex offender treatment programme began with Turner (1992). He found various negative effects which were attributed to the impact of this work; a third of the respondents with partners, felt their intimate relationships had been negatively affected. More than a third of those with children expressed concern that their behaviours with their own children had changed (being over-protective, feeling self conscious around their own children, feeling concerned about whether their behaviour had hidden meaning). Dean and Barnett (2010), also researching HM Prison Service therapists, classified the negative treatment experiences into three areas; cognitive processes, emotions and behaviours. Cognitive effects included impact on the thoughts and beliefs therapists have about themselves (e.g. personal schema related safety, intimacy and gender identity, Rich, 1997), others (e.g. increased suspiciousness and mistrust, Farrenkopf, 1992), and their environment (e.g. the Criminal Justice systems, Jackson, 1997). Other changes which have been described in the literature include increased hyper-vigilance, difficulty making decisions, intrusive imagery and increased rumination, (Farrenkopf, 1992; Turner, 1993). Emotional effects included increased levels of depression, loss of confidence in effectiveness, anxiety and helplessness, (Rich, 1997). Therapists who work with sexual offenders have also reported diminished hope, increased cynicism and pessimism, emotional hardening (a “dulling of emotions” or “emotional distancing”) and exhaustion (Farrenkopf, 1992). In terms of behavioural effects, these included becoming more intolerant of others (Jackson, Holzman, Barnard, and Paradis, 1997) and changes to sexual arousal and activity (Bengis, 1997). Farrenkopf (1992) reported that those who suffered emotional hardening tended to have difficulty feeling and showing empathy for their clients, and this hardening often extended beyond the consulting room to the therapists’ personal relationships.

Other forms of external perceptions of treatment provision have also been found to impact on therapists. Sheridan (1994) outlined that SOTP treatment facilitators reported a lack of support for the programme within the organisation. This included the fact that staff involved in the

programme were perceived by other staff as not doing 'real work' (i.e. not doing their fair share of the tasks necessary to run a wing). They noted a lack of confidence in the worth of sex offender treatment.

Clarke and Roger (2007) in a study of 182 treatment providers of sex offender treatment in HM Prison Service, referred to three factors affecting treatment providers in their work with sexual offenders: negative reactivity to offenders (NRO), ruminating vulnerability (RV) and organisational dissatisfaction (OD). The NRO factor reflected issues such as increased cynicism, anger and frustration (Farrenkopf, 1992) and depersonalization of clients (Ellerby, 1998). RV items included reference to increased feelings of vulnerability, intrusive images and fears for personal safety (e.g. Jackson *et al.*, 1997), and items in the OD factor incorporated concerns about support and organisational recognition. The results suggested an association between rumination and therapists' dissatisfaction with the organisation, specifically, perceived support from managers and peers. This might take the form of poor collegial support, or at a systems level, poor managerial training or unstructured promotion routes, all of which characterise the organisational dissatisfaction factor.

Community reaction to sex offender treatment has been highlighted as a cause of dissonance for providers that may result in increased defensiveness (Jackson, Holzman, Barnard, and Paradis, 1997). Treatment providers may be subjected to accusations that too little is done for victims of sexual offences, or that working with sex offenders implies acting as protective advocates of their behaviour. Lea, Auburn and Kibblewhite (1999) proposed that the nature of their close work with a socially stigmatized group may place clinicians in a counter-attitudinal position, making them vulnerable to attracting a stigma by association.

It is clear therefore, that therapists working with sexual offenders report both positive and negative experiences in treatment. It remains unclear, however, how this experience impacts on

their behaviour or therapeutic alliance in treatment. No research attention has been paid to the differential impact of treatment experiences on therapists. There appears to be a complex interaction at play which warrants further research attention.

Working with sexual offenders; the positive experiences: There is also a body of literature which reports on positive experiences in sex offender therapy. Farrenkopf's (1992) research revealed that 17% of respondents noted positive personal effects of working with sexual offenders, including increased sensitivity and empathetic traits, and more consideration in sexual relations with partners. Huffam (2001) outlined that there were positive aspects of their work, noting for example, maintaining a diverse workload. A "balancing act model" was used to explain the process therapists used to cope with the impact of their work.

In relation to treatment delivery within HM Prison Service, Turner (1992) reported that 96% of practitioners working with sex offenders described their involvement as a positive experience which provided them with a sense of achievement. Dean and Barnett (2010) reported that the positive aspects of treatment with sex offenders was the increased sense of autonomy, and the opportunity for professional development.

In other contexts, Scheela (2001), reported that clinicians perceived their work as "a challenge and privilege" (p. 749), gaining reward through teamwork, positive client change and a perception of community protection. Other researchers have also detailed why some therapists find this work to be rewarding and meaningful. This has included; a sense of protecting the public, contributing to offender change and wellness, connection to colleagues, personal empowerment and enjoying the professional benefits and growth (for a review see Kadambi and Truscott, 2003). Similarly, Ellerby (1998) in his study of 686 North American treatment providers, employed the MBI (Maslach and Jackson, 1981), the Compassion Fatigue Self-Test (CFST – Figley, 1995), the Personal Resources

Questionnaire (PRR – Osipow and Spokane, 1981) and demographic information, to assess the breadth and depth of impact. He reported high levels of personal accomplishment.

A consistent finding in studies exploring the impact of clinical work with sexual offenders is that practitioners can experience a strong sense of meaning, purpose and belief that their work is reducing the risk of violent and sexual recidivism, (Farrenkopf, 1992; Jackson *et al.* 1997). Scheela (2001) noted the following positive impacts for working with sexual offenders; working as a team, witnessing the offenders' growth and change, and contributing to the safety of the community. Slater and Lambie (2011) also describe the "high" from witnessing change in clients. Scheela also noted that therapists were excited about working in a challenging new area.

In summarising the positive experiences literature, three main areas have been outlined for therapists working with sexual offenders have outlined. These are; witnessing positive change in offenders, protecting the public (having meaning, purpose and beliefs, community protection), and professional benefits (personal development, personal growth, sense of achievement, teamwork, connection to colleagues).

Managing the potential negative effects of working with sexual offenders: the mitigating factor: Research has also shown that the work of the therapist is often stressful. A range of different stress responses have been reported in this work. Clearly, any stress response could have a negative impact on the therapist's well being and their approach to work. It is therefore, important that the potential negative impact of the work is managed effectively, to ensure therapist well being and thereby enhance the likelihood of treatment success. Effective management of the potential negative impact can best occur through capitalising upon mitigating factors which research has identified.

The most important mitigating factor is support. The provision of support has been cited by therapists as mitigating the effects of delivery. Therapists who report having limited opportunity to

participate in clinical supervision have been found to feel higher levels of distress and burnout (Ellerby, 1998). Collegiate or peer support has been associated with a sense of personal accomplishment and less psychological distress (for a review see Ennis and Horne, 2003). Support from other sex offender therapists has been cited as the most frequently used method of coping with treatment delivery, especially when compared with use of support from family, friends and other criminal justice representatives (Jackson *et al.*, 1997). The importance of support from others at work was highlighted by Scheela (2001). Support included opportunities to process issues and concerns formally and informally with colleagues, have good supervision, make decisions as a team so that no one person had to shoulder all the responsibility, and continue to learn more about sexual abuse and offender treatment. The need for such support has been repeatedly cited in the literature, most recently by Clarke and Roger (2007).

Dean and Barnett (2010) also highlighted the importance of support for therapists engaged in this sort of work but they go further. They highlight the importance of the context in which treatment is delivered. Factors which have been found to mitigate against stress in the organizational context include level of appropriate training, internal politics and punitive attitudes of non-therapeutic colleagues (see Ellerby, 1998 for a review). Dean and Barnett also consider that the provision of regular, structured supervision to direct and guide practice as well as to provide space for personal reflection seems to be particularly important, as do opportunities for therapists to share their experiences following sessions. Indeed the authors noted that there was no type of support which seemed to be detrimental to wellbeing.

Individual differences in coping responses have also been reported as mitigating the impact of negative consequences. For example, proneness to rumination has been highlighted by Clarke and Roger (2007) and Turner (1993). Clarke and Roger also suggest that the nature of the impact therapists experience from engaging in such work may also depend upon how psychological processes are managed by therapists over time (Clarke and Roger, 2007). Scheela (2001) reported

that therapists used personal coping strategies to deal with this work. They described using emotional detachment strategies to avoid bringing the job home with them. Humour was seen as an important coping strategy for the therapists.

4.12 Working with intellectually disabled individuals: therapist experiences

There is a paucity of literature relating to the experience of therapists working with ID individuals and the research which is available is very one sided. It seems that working with individuals with intellectual disabilities is a negative experience, there are no studies which describe positive experiences of working with this client group.

Working with IDSOs; the negative experience: Work with this client group is often described as “challenging” with stress being cited as a common experience for therapists involved in their treatment. Indeed Hatton *et al.*, (1999) found that up to one third of people working with ID clients had stress levels high enough to indicate a potential mental health problem. Such high levels of stress in so many members of staff is likely to impact on the ID individuals who the staff support. Various researchers report that burnout is a significant problem for staff working in the ID field generally (Dyer and Quine, 1998; Skirrow and Hatton, 2007). Burnout has also been associated with a feeling among staff that they put more into an organisation than the organisation gives them back (Chung, Corgett and Cumella, 1996; Skirrow and Hatton, 2007).

Burnout is not the only reaction to working with IDSOs. A variety of negative emotional reactions can follow, including fear (Langdon, Yagues and Kuipers, 2007; Mossman, Hastings and Brown, 2002; Rose and Cleary, 2007) which can, not surprisingly perhaps, result in high staff turnover (Hatton and Emerson, 1998).

Resident characteristics are commonly cited as having an impact on staff who work with intellectually disabled clients in community settings (Rose, David and Jones, 2003). Hatton, Brown, Caine, and Emerson (1995) reported that demands in the form of the emotional impact of the work

were linked to increased stress for some staff. Others have shown that the challenging behaviour of clients has an impact on staff (Bersani and Heifetz, 1987; Rose, 1993).

Organisational weaknesses can also exacerbate the situation. Work overload and pressure from management have also been shown to be important (Power and Sharpe, 1988). Allen *et al.*, (1990) found that staff reporting poorly defined roles led to ambiguity. Hatton and Emerson (1993) reported that poor promotion prospects and lack of training and skills development were also associated with staff stress. Rose and Schelewa-Davies (1997) associated stress with aspects of the team climate within the organisation. A lack of participation in organisational decision making has also been reported to be associated with stress (Hatton and Emerson, 1993). Low income (Bersani and Heifetz, 1987) and lack of job variety (Hatton and Emerson, 1993) have also been reported as being sources of stress.

To date, there are no studies reporting therapist's experience of positive factors in treatment with ID clients. It appears that the focus of the literature to date has been the negative experiences and methods for managing potential psychological harm as a result.

Managing the potential negative effects of working with intellectually disabled offenders: the mitigating factors: Once again, support is seen as a key variable. Low levels of support have been associated with high levels of stress in staff in a number of studies (Rose *et al.*, 2003). Support from other staff and immediate managers were seen as important moderators of stress and job satisfaction (see Alexander and Hegarty, 2000 and Ford and Honnor, 2000).

In conclusion, therapist characteristics are an important general responsivity factor. The style, attitude and approach taken by the therapist in treatment can have an important role in treatment outcome. Yet, to date, the literature pertaining to treatment effectiveness has not focused on the factors affecting the therapist and the potential impact of these on their behaviour in treatment. A review of the literature pertaining to treatment therapists has been provided. It seems that the

experience of working with both sexual offenders and intellectually disabled offenders is complicated. Both client groups are stressful to work with and many negative experiences are reported (Hatton *et al.*, 1999; Moulden and Firestone, 2010). But there is also a body of work suggesting that those working with sexual offenders can find their role satisfying and rewarding (but to date, this has not been reported in the ID literature). Support is described as mitigating the impact of this work. The literature pertaining to therapists working with sexual offenders also stresses the following mitigating factors; therapist individual characteristics, supervision, and training. A summary of the general responsivity factors identified in the literature review is provided in table 4.2.

Table 4. 2

Summary of the general responsivity factors identified in the therapist treatment experiences literature

Negative effects

Cognitive: cynical, increased suspicion and mistrust of others, difficulty making decisions, heightened awareness of sexual violence, increased defensiveness, depersonalisation of others, disturbing visual imagery about sexual violence, concern about personal safety, concern about gender identity, questioning beliefs about intimacy, increased rumination, diminished hope, dissatisfaction with organisation.

Emotional: “Dulled” emotions, emotional hardening, anger, frustration, depression, fatigue, irritability, loss of confidence, fear of own safety, anxiety, helplessness.

Behavioural: exhaustion, sleep disturbance, impact on relationship with partner, impact on relationship with children, change in own sexual behaviour, intolerant of others, difficulty feeling and showing empathy for others.

Positive effects

Positive change in offenders; witnessing offender change and wellness

Protecting the public; having meaning, purpose and beliefs; community protection, being at the “cutting edge.”

Professional benefits; personal development, personal growth, sense of achievement, teamwork, connection to colleagues.

Mitigating factors

Support from peers; processing issues and concerns, learning opportunities from others

Support from others; supervision, team decision making

Organisational support

Attitude of non therapeutic colleagues

Training

4.13 Concluding comments about general responsivity

In conclusion, it is fundamental to the principles of effective rehabilitation that treatment is responsive to the clients it is being offered to. There are four general responsivity factors which have been derived from the treatment outcome literature; treatment approach, group environment, therapist characteristics and treatment context. There is good evidence from methodologically sound research studies to support the use of a CBT approach with sexual offenders. There is no reason to think that CBT approaches for IDSOs, provided that they are adapted to meet the specific needs of IDSOs, should be any less successful. The Old Me New Me model has been described as a useful framework for use with IDSOs. The group environment also plays an important role in treatment outcome. The role of the therapist in the treatment programme is paramount, yet relatively little is known about the factors which influence their role in treatment. The contextual factors surrounding treatment delivery are important variables which are related to treatment success. Where treatment takes place (the setting), the organisational climate, the level of staff training and support and actual intensity or dosage of treatment must be considered. Factors which have been identified from the treatment participant's point of view have been outlined to add depth to our understanding of responsivity. To date the user's perspective of treatment has been largely ignored.

A review of the literature pertaining to the experience of treatment for therapists has been provided to explore the nature of this complex role. Paradoxically, it seems that for sex offender treatment providers there are both positive and negative consequences, yet for those working with individuals who have intellectual disabilities, to date only negative consequences have been reported. In order to ensure that treatment is delivered in a way which maximises the chances of success, in this thesis it is argued that the factors which affect therapist delivery must be considered as part of the treatment design process. These factors are important as general

responsivity factors in that therapist approach in treatment is likely to be affected by their wider experiences of treatment.

4.14 The Specific responsivity principle

The specific responsivity principle of the RNR model requires therapists to be responsive to the unique features of each client. As Harkins and Beech (2007) outline “Even if the treatment is offered in line with the risk principle, treatment addresses criminogenic needs/ dynamic risk factors, and the process variables are such that the therapeutic environment is conducive to change, factors specific to the individual ... are still going to play an important role in determining whether change occurs within that individual” (p619). The specific responsivity principle ensures that the factors pertaining to the individual are accommodated for as part of the treatment process. But to date, relatively little is known about these factors in relation to sexual offenders, and even less in relation to IDSOs.

In this section the specific responsivity factors which have been identified in the treatment outcome literature will be outlined. These are the factors which have been identified in various studies to relate to treatment success. Andrews and Bonta (2010) noted that the labelling of these specific responsivity factors is often complex because some specific responsivity may also be risk/need factors. He noted for example that psychopathic traits on the one hand, pertain to specific responsivity, but on the other are considered more widely as relating to antisocial personality variables which could be targeted as a criminogenic need.

4.15 The specific responsivity factors

A review of the treatment outcome literature pertaining to sexual offenders revealed four factors as having a relationship with outcome; motivation, denial, various demographic factors and interpersonal characteristics. Each of the factors will be considered in turn.

Motivation in treatment: An important issue in treatment is offender motivation to engage and change their behaviour. Clinicians suggest that any treatment approach relies on the participant engaging with the methods, techniques and concepts which are presented. Motivation in treatment is not a simple construct and its role in treatment is not clearly understood. Much of the discussion about the impact of motivation on treatment effectiveness has been based on clinical experience rather than empirical studies (Tierney and McCabe, 2002).

Empirically, the extent of risk reduction due to cooperation with treatment was examined in the Hanson and Morton – Bourgon (2004) meta analysis. The relationship between low motivation for treatment in relation to recidivism is non significant. However, engagement with treatment is found to reduce denial and increase the likelihood that the offender will make treatment progress (Levenson and Macgowan, 2004). The implication here is that offenders who are active participants in addressing their offending behaviour appear to be lower risk when compared to those who do not accept responsibility (a summary of this literature is provided by Harkins and Beech, 2007). Mann (1998, 2000) concludes that a treatment strategy for sexual offenders is unlikely to be successful however appropriately criminogenic its targets, unless it offers clients an inducement to change that they are convinced by, inspired by, and believe is in their best interests. Therefore, it is essential to incorporate motivational elements into treatment.

In relation to IDSOs, Lindsay, Mitchie and Lambrick (2010) noted that motivation is a constant issue for treatment in the community. Pessimistically, they noted that few referrals to treatment will show any motivation to address the issues of offending or desire to change their behaviour. In various studies presented by Lindsay and colleagues, strategies for encouraging motivation are presented, including the use of peer pressure to manipulate motivation in sessions. Haaven (2006b) suggests that to motivate clients we must understand and be willing to present treatment in a way that allows clients to assume ownership of and commitment to the process.

Denial: Historically, sexual offenders' motivation to change was considered to be associated with their level of denial or acceptance of responsibility for their offending (Looman *et al.*, 2005). However there is a vast spectrum between total denial and acceptance, with those who are described as 'total deniers' being different from those that are in 'partial denial'. Zimmerman (2007) proposes that denial in some cases can be linked to well-being and is a highly adaptive mechanism for dealing with stress (Snyder and Higgins, 1988). Mann, Hanson and Thornton (2010) suggest that denial may be protective for offenders demonstrating positive behavioural change, for example, avoidance of high risk situations. There is a contentious link between denial and recidivism. Most studies that have found a link have shown small effect sizes or have compared total deniers with acceptance whilst ignoring all of the variance between. Blagden, Winder, Thorne and Gregson (2011) completed a study exploring denial in sexual offenders by interviewing offenders and treatment providers. They found that there is no clear evidence that confession is needed for personal change or successful engagement in treatment. Kelly (2000) suggested that it is unfair to expect full openness and honesty and that it should not be demanded in treatment. Further to this, Lacombe (2008) warns of the danger of turning sexual offenders into "confession machines" and that treatment needs can be targeted without the person admitting their offence (Marshall *et al.*, 2001; Ware and Marshall, 2008).

Treatment work with IDSOs has traditionally focused heavily on addressing issues related to denial. Indeed Lindsay, Michie and Lambrick (2010) outlined the importance of addressing various different types of denial in treatment with this client group. They commented that some men may need months of treatment (up to 8 months is described) to achieve a state of "acceptance that an offence has taken place" (p282). This approach seems to be at odds with that advocated by Blagden *et al.*, (2011), and as such, it seems that the treatment of IDSOs who are denying aspects of their offending (as outlined by Lindsay *et al.*, 2010), is not in line with the latest recommendations in the sex offender literature.

In summary, the focus in the literature in relation to the treatment of men who are denying their offence/ aspects of their offending has changed over recent years. Historically, treatment approaches with sexual offenders have insisted on total honesty and openness. This appears to still be the focus of treatment approaches with IDSOs. Yet, more recent sex offender research has shown that the role of denial in treatment is complicated. It appears to play an important role in terms of client well being, enabling the client to come to terms with what they have done. Whether this is true for IDSOs is not yet known. In terms of treatment planning and design, it seems important that the role of denial is explored in treatment so that individual differences are taken into account.

Demographic Factors: There are a number of demographic factors which have been identified as important to treatment responsivity including age, gender, ethnicity, IQ and offence type.

Age and marital status (single, never been married) have been linked to treatment outcome in terms of recidivism (Hanson, 2001; Hanson and Bussière, 1998). The association between age and general criminal behaviour is well established (Hanson, 2001). Young people commit most crimes, and the recidivism rate gradually decreases with age (Hanson and Bussière, 1998); however, less is known about the relationship between age and sexual crime. Hanson (2001) reported that sexual recidivism decreases with age of release. Hanson also confirmed differential recidivism rates according to sexual offender types. The highest risk age period for rapists was between 18 to 24 years and for extra familial child molesters was between 25 and 35 years of age. Thornton and Doren (2002) reanalyzed Hanson's (2001) results, controlling for risk level, reporting a gradual decline in recidivism as offender's age. Offenders over 60 have the lowest recidivism rates regardless of risk level. However, in high-risk sexual offenders, the gradual decline in recidivism did not appear to be present. The trend was for sexual recidivism to increase with age until the age of 60 in high-risk sexual offenders. Strassberg, Whittaker, and Dillinger (2002) reported that age, marital status, and level of education were predictive of treatment completion. Age, marital status,

and non sexual juvenile criminal history successfully predicted treatment outcome for 67% of the sexual offenders. On the other hand, Shaw *et al.*, (1995) reported that being married was predictive of treatment completion but that age was not. Similarly, Gully, Mitchell, Butter, and Hardwood (1990) reported that age, ethnicity, and marital status did not differ between treatment successes and failures.

The literature generally supports the need for men and women offenders to be treated separately. It is argued that men and women are qualitatively different in that they develop differently, have different needs, and have different pathways to offending (summarised in Hubbard, 2007). Gender is therefore, considered to be a specific responsivity factor and the literature calls for the need for separate treatment approaches.

Attitudes and responses to sex offenders continue to be influenced by race (Wheeler and George, 2005). As such, ethnicity has been highlighted as a specific responsivity factor. Yet, this area has received little research attention. Patel and Lord (2001) did examine why ethnic minority prisoners are proportionately less likely to participate in the UK's Prison Service's Sex Offender Treatment Programme. Twenty four ethnic minority sex offenders who had completed the non ID sex offender treatment programme were asked about their experience of treatment and whether cultural needs had been met. The majority felt that SOTP did meet their treatment needs and that race and culture were not issues. The results suggested that negative experiences were generally less marked when there was more than one ethnic minority offender in a group.

IQ level has been previously described by some as a risk factor. In this thesis the literature to support the relevance of intelligence to the treatment approach has been provided under general responsivity (see 4.4). It is important that any treatment approach is adapted so that it is responsive to the learning styles and abilities of those who have intellectual disabilities. But it has also been argued that IQ level is a specific responsivity factor (Hubbard, 2002). As described in

chapter 1, the range of abilities and cognitive deficits within the classification of intellectual disability is huge. As such, someone with a borderline IQ score may benefit differently in treatment to someone with a much lower IQ score. It is important that treatment is effective for all treatment participants. Treatment design should take IQ level into account. To date, few studies have considered the significance of this.

Another specific responsivity factor relates to the type of offence that has committed. The literature is inconclusive in relation to whether sex offender groups are better when they contain mixed offender types or are composed of homogenous offender types (i.e. only those who have committed offences against adults, or only those who have offended against children). Harkins and Beech (2007) found that all types of groups indicated a relatively positive view of the group environment and there were no significant overall differences between groups. Cowburn (1990) argued that it was useful to have different types of offenders in groups because there is less risk that they will collude with one another. Economically, it has also been argued that mixed groups are most cost effective. However, Hayashino, Wurtele and Klebe (1995) found that child molesters differed from rapists, general offenders and non offenders in their fear of negative evaluation and level of cognitive distortions regarding children, and given this finding Harkins and Beech draw the conclusion that perhaps offence types should be separated in group. In exploring this, Tregaskis (2000) did not find the two types of group to differ in terms of the overall group environment. Harkins and Beech (2008) echoed these findings, reporting that there was no difference in the group environment between mixed groups or those who were exclusive to one type of sexual offending. Beech and Hamilton-Giachritsis (2005) also found no difference.

In conclusion, the sex offender literature reports that various demographic factors, notably age, gender, ethnicity, IQ and offence type are important specific responsivity factors which relate to treatment outcome. There is no specific literature base for IDSOs. As such, the applicability of these factors to IDSOs is assumed.

Individual factors: Intuitively, it could be expected that various individual factors might impact responsivity to treatment. The literature describes studies relating to level of anger and hostility, personality disorder, psychopathy, and mental health history. Each factor will be described in turn.

Various theories and models have suggested that anger and hostility are salient features of psychopathology for different types of sexual offending (Hall and Hirschman, 1991; Marshall and Barbaree, 1990). Lee, Pattison, Jackson, and Ward (2001) found support for the hypothesis that anger-hostility was a specific feature of psychopathology for rape. A hostile interpersonal style may impact a sexual offender's response to sexual offender treatment in a group setting (Preston, 2000). Bonta (1995) stated that many offenders in correctional centres have hostile, defensive, and aggressive interpersonal styles that impede their ability to engage in treatment. McKenzie *et al.*, (2002) reported that hostility and aggressiveness significantly predicted attrition in a high-intensity sexual offender treatment programme.

Hostility as measured by the Buss Durkee Hostility Scale (BDHI; Buss and Durkee, 1957) is comprised of two factors: an emotional hostility component (resentment and suspicion) and a physical hostility component (assault, indirect hostility, irritability, and verbal hostility). Among rapists, BDHI scores have been significantly higher than for those for non offending controls (Rada, Laws, and Kellner, 1976). Moreover, resentment and suspicion, could impact on treatment participation, impacting treatment gain, and subsequently recidivism rates. Physical hostility, could lead to discharge from treatment as well as difficulties with institutional behaviour.

The very nature of certain personality disorders often predisposes individuals to be resistant to treatment. The prevalence of personality disorder is higher among offender populations than the general public (Timmerman and Emmelkamp, 2001). The research examining the impact of personality disorder on sexual offender treatment outcome in terms of attrition is equivocal. Several researchers have reported that dropouts were more likely to have a personality disorder

(Abel *et al.*, 1989; Moore, Bergman, and Knox, 1999). Similarly, Barbaree, Seto, and Maric (1996) reported that sexual offenders who refused treatment were more likely (21.2% vs. 7.2%) to have a diagnosis of antisocial personality disorder. On the other hand, Shaw *et al.*, (1995) reported that antisocial personality disorder was not related to attrition rates.

There is some debate in the forensic treatment literature regarding the question of whether men diagnosed as psychopaths are responsive to treatment they receive (Wong, 2000). Salekin (2002) examined the effectiveness of treatment with psychopaths via meta analytical statistical techniques reporting on 42 studies. He reported an overall average success rate of .62 for treated psychopaths. Cognitive behavioural approaches had an average success rate of .62, and those that employed both cognitive-behavioural and insight approaches averaged .86. Salekin concluded that highly structured, intensive treatment programs can be successful in treating psychopaths. Looman, Abracen, Serin, and Marquis, (2005) examined the outcome of 102 sex offenders following completion of an intensive, inpatient treatment programme. The average score on the PCL-R was 22.5 (SD = 7.64), with approximately 45% of the sample scoring higher than 25. An overall rating of whether the client's risk to reoffend was reduced through treatment was made. This rating was based not only on performance in groups and on homework assignments, but also on the client's behaviour outside the formal treatment programme. In addition, this risk rating was anchored by the client's pre treatment risk level, as assessed by structured risk assessment tools (including the PCL-R). The authors found that performance ratings were not associated with post treatment recidivism. However, an association between the overall risk rating and recidivism was found. Men assessed as having their risk reduced following treatment recidivated at a lower rate. High - psychopathy offenders (i.e., scores higher than 25), who were assessed as having benefited from treatment, reoffended at a rate more similar to the low psychopathy offenders than their high psychopathy counterparts who were not assessed as benefiting. Looman *et al.*, conclude that from

these findings that some psychopathic sexual offenders can benefit from a highly structured, inpatient treatment program that has a relapse prevention component.

There is a paucity of studies relating to the treatment of those with ID and psychopathic traits (Morrissey, 2010). Torr (2003) noted that there is no evidence that those with ID and personality disorder do less well in treatment. However, Morrissey, Mooney, Hogue, Lindsay and Taylor (2007) suggested that treatment may need to be lengthier in personality disordered patients with ID.

The research which has examined the relationship between mental health variables, such as past history of self-harm or suicide attempts, sexual abuse, and responsivity in high-risk sexual offender populations is also weak. However, Looman *et al.*, (2005) describe these variables as suggestive of poor coping strategies that may influence treatment outcome in high-risk sexual offenders. Craissati and Beech (2001) reported that noncompliance was significantly associated with variables suggestive of psychological difficulties or trauma. Sexual offenders who had increased levels of contact with mental health services, two or more childhood disturbances, and a history of childhood sexual victimization were more likely to drop out. Past sexual abuse may influence the ability of certain sexual offenders to participate in treatment. The rate of sexual abuse in the sexual offender population is higher than in the non-sexual-offender population (Dhwan and Marshall, 1996; Langevin, Wright, and Handy, 1989). And the reported rates for abuse amongst IDSOs is particularly high (Thompson and Brown, 1997). Craissati and McClurg (1997) reported that one of the strongest variables predictive of attrition in sexual offender treatment was a history of childhood sexual victimization. The role of sexual abuse history in terms of effectiveness of treatment requires further examination given that attrition is related to higher levels of recidivism (Hanson and Bussière, 1998).

The research on the incidence of mental health in offenders suggests that approximately one third of those with ID also suffer from psychiatric illness (Haut and Brewster, 2010). Lindsay *et al.*,

(2004) reported on a community ID service. They compared sexual offenders with non sexual offenders. They found fairly equal numbers of patients who had diagnoses of mental illness (32% of the sexual offender group compared to 33% of the comparison group). Lambrick and Glaser (2004) also reported no difference between ID groups (sex offender and non sex offender) in terms of the incidence of mental illness. However, other researchers have reported much higher incidences of mental health problems in ID populations. For example, Lund (1990) reported that 91.7% of his 274 offender sample had a diagnoses of mental illness. Craig and Lindsay (2010) concluded that the differences in prevalence rates are likely to be a result of differences in definition. Further, they go on to suggest that “mental illness is not a primary motivating factor in the commission of sexual offences since the cohorts of individuals in the group whose offences were non sexual had similar rates of mental illness” (p20). As such, presence of mental illness appears to be a relevant specific responsivity factor but its role is not fully understood.

In conclusion, the general sex offender treatment outcome literature has identified motivation, denial, demographic and individual factors as the specific responsivity factors relating to treatment success. The demographic factors; notably IQ, gender, ethnicity, age and offence type and the interpersonal characteristics, anger and hostility have clear role within this literature. The research base is less clear in relation to the role of denial, personality disorder, psychopathy, and mental health history as specific responsivity factors in sex offender treatment. The role of any interaction between these factors is also not known. The specific responsivity factors identified in the literature may be differentially applicable to ID offenders. Allam, Middleton and Browne (1997) noted that the life experiences and perceptions of IDSOs may affect their ability to engage in treatment. Further research is needed to investigate the specific responsivity factors which apply to the treatment of IDSOs. A summary of the specific responsivity factors is given in table 4.3 below.

Table 4.3

Summary of the specific responsivity factors

Specific responsivity factors

Motivation

Denial

Demographic variables

Individual factors (self esteem, anger, hostility, personality disorder, psychopathy, and mental health history)

4.16 Concluding comments

In this chapter, a review of the literature pertaining to treatment outcome and process has been undertaken to define the relevant factors relating to general and specific responsivity. The application of these factors to the treatment of IDSOs has been described.

The treatment outcome literature identifies four general responsivity factors which relate to treatment success; the treatment approach (CBT approaches have proven applicability to successful sex offender treatment), group environment (cohesive well led supportive groups have result in individual treatment success), therapist characteristics (warm, supportive, empathic therapeutic style is related to treatment success) and treatment context (the treatment setting, organisational climate, level of staff training and support and the intensity of treatment all relate to treatment success). The participant treatment experience literature helps provide meaning to these factors and enables our understanding of the impact of these factors in treatment. The importance of the therapist in treatment has been identified in both literature bases. Yet, our understanding of this complex role is limited. Clearly, any responsivity factors affecting therapists are likely to impact treatment success? As such a review of the literature has been undertaken to explore the treatment experience from the therapists' perspective. Taken together, the knowledge base about the general responsivity factors which contribute to the success of sex offender treatment (and IDSOs) has been expanded.

The treatment outcome literature identifies four specific responsivity factors; motivation, denial, demographic and interpersonal characteristics. Relatively little is known about the role of these factors in the treatment of sexual offenders. There is little literature which pertains specifically to IDSOs. Given that this group are not homogenous, it is likely that there are specific responsivity factors pertaining to this client group which as yet have not been specified.

Despite the limitations with the literature, it is important that any treatment planning or design process acknowledges the evidence that does exist. The general and specific responsivity factors identified within this chapter are therefore critical for BNM treatment design. It is essential that any treatment approach is planned with these factors in mind to maximise adherence to the responsivity principle. This is particularly true in relation to the treatment of this specific client group as they are likely to be particularly vulnerable to any issues relating to poor responsivity.

In previous chapters of this thesis, a review of the literature revealed the RNR model as the only empirically validated rehabilitation model. The risk, need and responsivity principles were explored and the research pertaining to sexual offenders, and more specifically to IDSOs, has been described. Various gaps in the research have been highlighted and where suitable, recommendations for accommodations have been outlined. In chapter 5, the application of the literature to the development of a treatment approach for this client group is outlined. More specifically, the design of the Becoming New Me programme is described.

Chapter 5: The development of the BNM Programme in line with the RNR model

The previous chapters have outlined the principles of effective rehabilitative programmes: risk, need and responsivity. Each principle has been reviewed and their relevance to the treatment of IDSOs has been explained. The gaps in the literature with respect to IDSOs have been identified. The focus in this chapter is on the application of the evidence to the development of the BNM programme. As such, a description of how the BNM was planned to adhere to the RNR principles is provided. In subsequent chapters, the effectiveness of these plans will be tested.

5.1 Meeting the risk principle

Research suggests that individuals of lower risk can in fact raise their risk level through overtreatment (Andrews and Dowden, 2007). As such, a decision was taken by NOMS that lower risk men should not be eligible for BNM (their needs will be met via alternative means). The BNM was developed for medium, high and very high risk men only. Risk level is determined via static risk assessment (RM2000/s) (see chapter 2. 4).

5.2 Meeting the Need principle

The Need Principle states that if an intervention is to reduce rates of sexual recidivism it must target factors that have been proven to relate to recidivism, otherwise known as criminogenic needs. HM Prison and Probation Services use the Structured Assessment of Risk and Need (SARN) to assess criminogenic need for both ID and non-ID sex offenders (please see 3.4 for further detail). Psychometric measures are used to help identify criminogenic needs in IDSOs.

Targeting criminogenic needs: the BNM psychometric assessment battery

The four areas of criminogenic need which sex offender treatment programme should target have been previously outlined in 3.2. Psychometric testing to assess criminogenic needs in sexual

offenders is widely used throughout HM Prison and Probation settings and elsewhere in the world to assess criminogenic needs. An assessment battery to measure the criminogenic needs of IDSOs was needed as part of the BNM programme. A review of the literature revealed that there are few psychometric measures which have been developed and validated specifically for IDSOs (Lindsay, 2002). The existing measures for IDSOs which apply to each of the criminogenic areas of need are described below.

Offence related sexual interests: “There is very little in the way of standardised, valid and reliable measures of sexual deviance and sexual interests that can be used with sex offenders who have ID” (Langdon and Murphy, 2010, p240). The most commonly used assessment with non ID offenders is the Multiphasic Sex Inventory (MSI; Nichols and Molinder, 1984). However, it has not been standardised on ID populations and given that it consists of 300 items and uses fairly complex language, it is considered to pose significant problems for this client group (Craig, Stringer and Moss, 2006). Similarly, the Wilson Sex Fantasy Questionnaire (Wilson, 1988) is also reported to be difficult to use with this client group. There is to date, no existing measure available to assess this criminogenic need in IDSOs.

Offence supportive attitudes: The assessment of cognitive distortions has received some attention by those working with IDSOs. Keeling, Beech and Rose (2007) reviewed the use of the Abel- Becker Cognition Scale with IDSOs and concluded that it does not reliably distinguish between sex offenders and non offenders with ID. The Questionnaire on Attitudes Consistent with Sexual Offending (QACSO) (Broxholme and Lindsay, 2003; Lindsay, Michie, Whitefield, Martin, Grieve and Carson, 2005; Lindsay, Whitefield and Carson, 2007) was developed specifically to assess distorted thinking with this client group. The questionnaire attempts to assess distorted cognitions relating to sexual offending spread across several different offending categories, which include 1) rape, 2) voyeurism, 3) exhibitionism, 4) dating abuse, 5) homosexual assault, 6) paedophilia, and 7) stalking and sexual harassment. Higher scores indicate increased endorsement of distorted cognitions

associated with sexual offending. The 63 item scale has been reported to have good internal reliability (Cronbach $\alpha = .95$) and test retest reliability (using Spearman's rank correlation) after one month. The stability of the subscales ranged from .56 to .90, with stability for the overall scale reported as .96 for the IDSO group. Discriminant group validity was also tested; sexual offenders were found to give significantly more socially inappropriate responses than ID offenders and normal controls. The validity of the scale was also tested using Spearman's rank correlation. Correlations ranged from 0.41 to .91, all subsection total scores correlated significantly and positively with each other and with the QACSO total score suggesting that the subsections measure similar constructs and that the QACSO as a whole is one scale (Broxholme and Lindsay, 2003). Langdon, Maxted, Murphy (2007) and Williams, Wakeling and Webster (2007) reported on the usefulness of the Sex Offenders Self Appraisal Scale (SOSAS) describing good levels of internal consistency in both studies. The SOSAS (14 items) examines denial, minimization and justification of the respondents's own offending. The Sex Offender's Opinion Test (SOOT; Bray, 1997) has also been described as useful psychometrically in the assessment of offence supportive attitudes within the Williams *et al.*, study. The 20 item SOOT measures attitudes about victims of sexual offences in general.

There are therefore 3 assessments that have reported usefulness in assessing offence related attitudes amongst IDSOs. All of the measures were in development at approximately the same time. Given that the SOOT and SOSAS were under development within HM Prison Service, and the fact that the SOOT and SOSAS are considerably shorter in length, the decision was taken to consider these measures for inclusion into the BNM battery. Our understanding of the criminogenic needs of sexual offenders, and specifically about the role that distorted thinking plays in sexual offending, has significantly increased in recent years. The role of denial, minimisation and justification in offending is no longer considered to be a barrier to treatment success (Mann, Thornton and

Hanson, 2010). As such, a decision was made to discard the SOSAS from the BNM psychometric battery as there was not a need to assess types of cognitive distortions.

Socio affective functioning: There are a few measures that aim to assess aspects of socio affective functioning in ID individuals, including a self esteem measure, a measure of emotional loneliness, and locus of control. The adapted self esteem questionnaire and the adapted loneliness scales were described within the Williams *et al.*, study (2007) to have good psychometric properties. The Adapted loneliness scale was however found to be insensitive to treatment change and the authors recommended that it should not be used for such a purpose. The Nowicki Strictland Internal external locus of control scale (Nowicki, 2000) has been used with IDSOs (Langdon and Talbot, 2006; Rose, Jenkins, O'Connor, Jones and Felce, 2002). In the latter study there was an unexpected increase in perceived external locus of control in IDSOs who had completed extensive treatment. This finding may be indicative of the wider concern about the usefulness of the locus of control concept to researchers. It has been suggested that the locus of control concept is overly simplistic (Weiner and Graham, 1999) and does not account for other dimensions of attributions, such as stability, globality, intentionality and controllability. In light of the information above, only the adapted self esteem measure appears to be of value in relation to the assessment of the socio affective functioning domain. As such, this assessment was included in the BNM battery.

Self management: The only measure reported is the adapted relapse prevention interview which is described in Williams *et al.*, (2007). This interview was designed to measure the extent to which respondents were aware of their risk factors and risk situations. It was divided into questions that focus on awareness of risk factors and questions which focus on the use of strategies to avoid or escape risk situations. The interview was designed around a model of relapse prevention which focused on avoidance or escape coping strategies. Given recent developments in relation to our understanding about approach focused goal strategies (Mann, Webster, Schofield

and Marshall, 2004), this interview was not considered to be appropriate for use within the BNM battery.

In summary, there are few assessments which have been specifically designed for use with IDSOs. Given our current understanding of the areas of criminogenic need which pertain to this group, there are few measures which tap into these needs. Williams *et al.* (2007) for example, identified some assessments which showed promise in the assessment of some treatment areas, but it is argued that some of these assessments did not map onto areas that are now known to be of criminogenic relevance.

5.3 The BNM assessment battery

A new assessment battery was developed which targetted appropriate criminogenic needs and was designed with the specific needs of the client group in mind. The adapted self esteem questionnaire and the SOOT assessment measures were adopted into the battery as there was existing information to support their usefulness with this client group.

Given that HM Prison Service had developed a battery of measures for non - ID sexual offenders, the possibility of adapting these measures for use with IDSOs was examined. Three measures were identified to assess the socio affective functioning area; the openness to men and women scales, the ruminations scale, and the relationship styles questionnaire. The impulsivity scale was identified for the self management domain. These measures were considered suitable for adaptation based on the length of the measure and the likely ease to which the measure could be adapted into an interview.

In adapting (or developing) any assessment measure for an ID population, it is important that adaptations are made to ensure their suitability. Lindsay (2002) reported that many of the existing assessments for sex offenders are too linguistically complicated. The language used must be familiar and simple. Information should be presented in 'easily digested chunks' (Hickey and Jones,

1996) in order to reduce the auditory memory load. That is, the use of interviews and interactive response methods are preferred over paper and pencil tests. All of the BNM assessments were designed as interviews. Reliability checks were also incorporated to make sure that the offender understood what was required. Furthermore, where possible, information obtained from the offender was cross-referenced with file information. All the assessments include the repetition of instructions and the use of prompts to reword the instructions. The response scales use the minimum number of words possible. The use of symbols/ gestures was also incorporated where possible.

There was however, no existing measure for the assessment of offence related sexual interests in IDSOs. All of the existing measures are lengthy involving a large number of items. A need for a simpler and shorter assessment specifically to meet the needs of IDSOs was identified. Consequently, the My Private Interests (MPI) measure was developed specifically for the battery. In order to stimulate ideas for item development reference to existing measures for non ID offenders was made.

Table 5.1 highlights how the BNM Psychometrics map onto the criminogenic needs of IDSOs. It is acknowledged that there are some gaps in the assessment battery where no measure was available. These criminogenic needs are targeted in treatment, but as yet, there is no psychometric tool available to use for assessment purposes.

Table 5. 1

Mapping the criminogenic Needs of IDSOs to the BNM psychometrics

Criminogenic needs (based on SARN framework)	Psychometric Measure
Offence related sexual interests	
Sexual preoccupation/obsessed with sex.	My Private Interests Measure (MPIM)
Sexual preference for children.	My Private Interests Measure (MPIM)
Preferring sex to include violence or humiliation.	My Private Interests Measure (MPIM)
Other offence-related sexual interest.	My Private Interests Measure (MPIM)
Offence supportive attitudes	
Believing men should dominate women.	No available measure
Believing you have a right to sex.	No available measure
Child abuse supportive beliefs.	SOOT
Beliefs that women can't be trusted.	SOOT
Socio affective functioning	
Feeling inadequate.	Adapted Self Esteem Questionnaire
Feeling more comfortable with children than adults.	Adapted Openness to Women Scale
Suspicious, angry and vengeful towards other people.	Adapted Openness to Men Scale
Not having an intimate relationship.	Adapted Ruminations Scale
Self-Management	
Impulsive, unstable lifestyle.	Adapted Relationship Style Questionnaire
Not knowing how to solve life's problems.	Adapted Impulsivity Scale
Out of control emotions or urges.	No available measure
	No available measure

Given that the adapted assessments and the new MPI assessment were all newly developed for the BNM battery, there was a need to establish the psychometric properties of each assessment.

5.4 Meeting the general responsivity principle: treatment approach

The applicability of the CBT approach for IDSOs has been demonstrated, however, adaptations were recommended to improve treatment success (see chapter 4.5). Table 5.2 below summarises how the CBT approach was adapted for IDSOs within BNM programme design.

Table 5. 2

The BNM: Accommodations made in the BNM design to ensure a responsive treatment approach

General responsivity factor	Accommodation within the BNM treatment design
Treatment approach	Use of the adapted CBT approach; Old Me New Me model. Engaging multi modal treatment approach. Adaptations to treatment in line with Hurley <i>et al.</i> , (1998). Use of humour and fun. Supervision of therapists. Opportunity for Individual sessions alongside group sessions. Providing opportunities to celebrate treatment success (use of the learning log, story telling). Encouraging resilience and perseverance in treatment (reinforcing examples of these behaviours, providing opportunities for support out of session). Additional support provided during stressful parts of the programme. Support from “significant others” is encouraged during treatment. Opportunities provided for “others” to attend the mid treatment and end of treatment reviews. Local structures are encouraged to provide support out of group; one to one sessions, peer group support sessions, wing mentor schemes etc. Local monitoring of sessions by experienced supervisor. Supervision of therapists. Training of therapists.

The BNM treatment programme: The BNM Adapted programme is divided into 12 treatment blocks. It is group work based treatment approach for 5 – 8 group members. It provided approximately 200 hours worth of treatment which is divided into 2 hourly sessions. Rate of delivery varies across sites, but typically the group meet 3 or 4 times per week for 6 – 9 months. Before starting treatment in many establishments, group members come together to complete group cohesion exercises. When BNM commences, therefore, the men are familiar and confident with each other. In table 5.3, the application of the treatment techniques to the goals of treatment are described.

Table 5. 3

The BNM; treatment targets, treatment goals and treatment methods (CBT techniques)

Target (criminogenic need)	Treatment goals	CBT techniques
Offence related sexual interest	To identify any sexual interests that played a part in offending behaviour. To recognise the risk of deviant sexual thoughts/ feelings. To be able to monitor sexual interests/ feelings on a day to day basis. To manage deviant sexual interests/ feelings appropriately. To develop adult oriented and consensual sexual interests. To have proportionate interest in sex.	Old Me/ New Me poster work. Life Maps. Offence disclosure. Group discussion. Use of symbols and pictorial images to promote discussion. Maintaining a log of day to day sexual interests/feelings (recognising risk as appropriate). Role playing of day to day situations from the log to enable personal and group learning. Story telling – sharing success.
Offence supportive attitudes	To recognise any offence supportive thinking that played a role in the offending. To monitor and challenge any current offence supportive thinking. To develop adult oriented and consensual thoughts about sex. To explore feelings in others and enable recognition of how other people feel. To recognise the impact of offending behaviour on others – to include the victim/s and their family/ friends. To explore any empathy deficits in relation to any ‘offence supportive attitudes’. To understand the concept of caring for others.	Old Me/ New Me poster work. Life Maps. Offence disclosure. Victim harm work. Group discussion. Socratic questioning. Maintaining a log of day to day events that might trigger offence supportive thinking. Skills practice: role play of day to day situations from the log to enable personal and group learning. Story telling - sharing success. Use of pictures to promote group discussion. Poster making: the effects on my victim and their family/ friends. Cognitive restructuring of any empathy deficits in relation to offence supportive attitudes.
Socio affective functioning	To recognise how poor relationships skills played a part in the offending behaviour. To improve social and interpersonal skills. To develop skills that will aid the development of a long term close relationship. To improve emotion management (dealing with positive and negative	Life Map. Old Me/ New Me poster work. Offence disclosure. Skills training. Identifying, building and maintaining a support network – support spiders. Identifying building and maintaining wrap around services – support spiders.

	emotions). To develop links with others who can help in the future (support and/or wrap around). To develop a respectful and caring attitude to others. To increase confidence and self esteem To develop a “success identity” (New Me). To practice skills relating to self efficacy. Reinforce success stories/ experiences. To build a support network.	Involving support network and wrap around services in treatment. New me strengths work. Use of symbols and pictures to promote group discussion. Maintaining a log of day to day events that might trigger relevant thoughts or feelings (relationship concerns, management of social situations, feelings of loneliness). Skills practice: role play of day to day situations from the log to enable personal and group learning. Story telling - sharing success.
Self management	To explore the impact of impulsive decision making and out of control emotions/ urges in offending. To improve problem solving techniques. To improve self management of thoughts and feelings. To plan for the future. To practise as New Me dealing with risks.	Life Map. Old Me/ New Me poster work. Skills training – problem solving skills, assertiveness training. Maintaining a log of day to day events. Skills practice: role play of day to day situations from the log to enable personal and group learning. Story telling - sharing success.

5.5 Meeting the general responsivity principle; group environment

The importance of a cohesive supportive group to IDSO treatment success has been outlined in 4.6. The BNM is a closed treatment programme to maximise opportunities for group members to form strong bonds and relationships both with the therapists and the other group members. This is especially important for this group given their reported difficulties in forming and maintaining relationships. Exercises which provide opportunities to practice relationship and social skills are maximised in treatment. The group members on BNM have mixed offending backgrounds, it is not practical to separate child from adult offenders in treatment.

A summary of the accommodations in relation to group environment made within the BNM design is given in Table 5.4.

Table 5. 4

*Summary of the accommodations made within the BNM design to ensure that the group environment general
Responsivity factor is adhered to*

General responsivity factor	Accommodation within the BNM treatment design
Group environment	Pre treatment gelling. Closed treatment groups (once the group has started, no new group members can join). Therapists are required to commit to a group, Unless there are exceptional circumstances, therapists will not leave the group. Group size – flexible between 5 – 8 group members. Co working between peers. Exercises which promote peer support. Selection of group members to ensure an appropriate “mix” of offence types in groups. Local monitoring of sessions by experienced supervisor. Supervision of therapists. Training of therapists.

5.6 Meeting the general responsivity principle; therapist characteristics

In their discussion of the general responsivity principle, Andrews and Bonta (2006) show that it is not so much the adoption of a CBT approach that produces effectiveness, but rather whether or not therapists are carefully selected for, and trained in, the appropriate skills. These skills include: empathy, warmth, respect, interest, and non blaming communication. Yet our understanding of this factor from the treatment outcome literature remains limited. It has been summarised below in table 5.5.

Table 5. 5

*Summary of the accommodations made within the BNM design to ensure that the therapist characteristics general
Responsivity factor is adhered to*

General responsivity factor	Accommodation within the BNM treatment design
Therapist characteristics	Careful selection of therapists. Training of therapists. Local monitoring of sessions by experienced supervisor. Supervision of therapists.

In order to advance our understanding of this factor, a review of the process evaluation literature pertaining to treatment experience was undertaken in chapter 4. How this important responsivity factor was addressed within the design of the BNM programme is discussed in the following section.

Firstly, the selection and training of non ID programme therapists will be considered followed by the selection and training of BNM therapists. It has been pointed out that the personal qualities of the facilitators, rather than their professional qualifications, are the important factors in the delivery of treatment to sexual offenders (Mann and Thornton, 1998). Coleman and Haaven (1998) also suggested that clinicians should look for 'someone with the appropriate attitude and aptitude rather than a particular degree' when seeking therapists to work with ID clients. They continue, 'working effectively with this intellectually disabled person requires someone who does not feel sorry for their client, but feels respect, is aware of limitations and is able to follow through on consequences' (p. 279). Wilcox (2004) suggested that because IDSOs are dispersed throughout the Criminal Justice and mental health systems, no one professional group has the resources or expertise to work with them. Leonard, Shanahan and Hillery (2005) similarly advocate that this work is undertaken by multi disciplinary teams. The BNM programme has been designed to be delivered by lay therapists or 'para professionals' (Grubin and Thornton, 1994, Mann and Thornton, 1998).

The selection and training of these para professional therapists is therefore very important. Any therapist wishing to work therapeutically with sexual offenders is subject to a careful selection process. This process has been devised on the basis of Clarke's (2004) research which examined the psychological impact on Sex Offender Treatment Programme (SOTP) facilitators of working therapeutically with sex offenders. This research was undertaken with over 300 SOTP facilitators. Respondents came from a variety of disciplines including prison officers, psychologists, probation

staff, educational staff and chaplains. The respondents included therapists who worked with both ID and non ID sexual offenders.

The negative effects identified could be broadly categorised into three domains: Negative Reactivity to Offenders (NRO), Ruminative Vulnerability (RV), and Organisational Dissatisfaction (OD). Neither qualification level nor occupation was found to be associated with levels of distress. The key findings were that facilitators with a detached coping style experience less distress, and those with a more ruminative emotional response style experience more distress. Although empathy is a critical therapist skill, it is implicated in higher levels of personal distress. In the first year of facilitating, facilitators report an increase in Emotion Inhibition and Rumination and a decrease in satisfaction with their role and empathic concern. As such, all potential SOTP therapists are given reading materials about the likely impact of working with this client group and are asked to complete a battery of psychometric tests as part of the application process. The results of these assessments are used to provide managers with an idea of who would be vulnerable to stress if they went on to become a facilitator. They also allow managers to develop support plans for those identified as having a riskier profile. Applicants are also required to complete an application form outlining why they want to undertake this work and obtain a reference from their line manager. All applicants are then invited to an assessment centre. The assessment centre consists of a panel interview, a presentation exercise and a role play exercise. Successful completion on all aspects of the assessment centre is required before a training place is offered. The training to deliver sex offender treatment consists of a 2 week intensive course. Training courses are delivered nationally, led by the National Clinical Lead to ensure consistency. All trainees must demonstrate that they have the fundamental skills required of a SOTP therapist. Only those who successfully complete training are then able to return to their establishment and prepare to deliver treatment.

As far as the selection and training of BNM therapists is concerned, those who have successfully delivered at least one treatment programme with non ID sexual offenders, can apply to be

considered as a BNM facilitator if they so wish. Only those who have good scores from monitoring can apply to become a BNM therapist. A recommendation from their manager is needed to secure their application. Selection for suitability to become a BNM therapist is determined via another specifically designed assessment centre which is held locally at each treatment site. The assessment centre is designed to assess the competencies needed for working with this client group. Coleman and Haaven (2001) noted, 'an intellectually disabled person may be more hampered by the therapist's old fashioned and inept teaching methods than his own intellectual deficits' (p. 203). They observed that therapists tend to teach in the way they were taught, usually in large rooms with the teacher at some distance from the class using didactic methods and abstract formal lectures. As such, it is important that in the assessment centre, potential BNM therapists demonstrate that they have considered the specific characteristics, strengths and needs that ID participants might bring to treatment, that they are positive about working with this client group and that they have thought about ways in which they can adapt their therapeutic approach to accommodate the needs of this group. Only successful candidates can apply for a training place on the working with IDSOs training programme.

To prepare therapists for working with IDSOs, a four day training course structures therapist expectations about the characteristics of this population and the likely need for changes in their therapeutic approach. This is followed by a 5 day training course which is specifically designed to enable the successful delivery of the BNM treatment programme. This course allows for opportunities to practice skills with role players and has a practical focus on responsive treatment delivery. It is assessed. Only those who show the requisite competencies are assessed as suitable to deliver BNM.

As reported earlier, the literature emphasises that being a therapist in a treatment programme such as BNM, can give rise to strong emotions. These can be strong positive or negative emotions. As such, there are a range of structures in place designed to mitigate potential sources of stress.

For example, all newly trained therapists are paired with more experienced therapists on their first treatment group. There are also a range of support mechanisms in place. Three therapists are assigned to every group, with 2 therapists required in every session. This team of therapists is supervised by an experienced supervisor or treatment manager who has proven skills in treatment delivery. All treatment sessions are recorded and regular monitoring of treatment delivery by the group supervisor is a requirement. As such, therapists receive regular feedback on their performance and the applicability of their approach in accordance with the prescribed treatment approach. This feedback is provided as part of the supervision requirement. Supervision of therapists must take place regularly (at least one 2 hour session for every 10 sessions of treatment). This supervision session must address facilitator needs and also group member needs. It is a forum for enabling discussion about co working and other facilitator related issues. It also allows for a review of the group members and their progress towards meeting their criminogenic needs. Other support opportunities are also required. Regular monthly meetings are held for all therapists at each site. These may be supplemented by local training initiatives. Additionally, therapists are required to attend personal counselling sessions with a counsellor at least 3 times during the course of treatment. These sessions are mandatory and should be focused on ensuring the health of the facilitator. Therapists are able to attend various national “top up” training programmes to keep their skills alive and advance their therapeutic approach. These training programmes tend to focus on role play techniques and also on methods for “staying strong,” developing resilience for working with this client group. There are various other facilitator health checks and support structures built into the delivery of treatment, including health checks and one to one supervision sessions for new facilitators and “MOT reviews” for those who have been involved in SOTP for 4 years or more. All facilitators are required to take breaks from treatment following the end of a group to enable time out from this work. Any therapist can, of course, choose to withdraw from this work at any point.

The treatment supervisors and managers are a key group in relation to the delivery of the BNM. They have a complex role within their local organisation. They are often the only person in the organisation whose primary concern is clinical integrity and treatment quality. They often have responsibility for a pool of multidisciplinary therapists whose welfare and training needs must be considered. They are also responsible for all decisions regarding group member selection and treatment provision and as such are the first port of call for any legal representatives. Yet, they are also held responsible for ensuring that treatment work is effective and that it adheres to strict time frames and other organisational pressures. Maintaining their interest and support in this work is vitally important for the success of the BNM approach. As such a number of different strategies have been put in place to provide avenues for support and development for this group of staff. National meetings with all treatment managers are held annually. They are invited to attend on working parties to develop new treatment approaches/ ideas. They are invited to contribute to National training and are able to attend various training courses designed for experienced treatment providers.

The literature relating to therapists working with sexual offenders, also emphasises the positive aspects of working with this client group. As such, it is important that in treatment design provision is made to maximise opportunities to celebrate the positive aspects of the work. Many of the strategies used are also in place to mitigate the potential negative aspects of this work, thus enabling these strategies to provide a dual and balanced purpose. Additionally, there are a number of strategies used to celebrate success within the treatment design. For example, therapist success is celebrated and reinforced during supervision sessions. Supervisor training advocates that feedback is given to therapists in a format which highlights both the strengths of their delivery style and areas for improvement. The focus is on building on successful delivery. Opportunities to share successful treatment approaches are also provided during team meetings and at national meetings. Summaries and examples of good practice are shared at national meetings for others to learn from.

There are also opportunities to share good practice at “Top up” training courses/ conferences, enabling therapists to share their work with other treatment sites. Therapists/ treatment supervisors have opportunities to share their work with others in working parties which are set up to develop new treatment practices or approaches. There are also opportunities for good therapists to help with national training events for new facilitators. At the end of each group, the Governor of the prison is invited to the final session to celebrate the end of the group. This serves the dual purpose of signalling success for both the participants and the therapists. A summary of the factors identified by therapists relating to general responsivity is provided in Table 5.6.

Table 5. 6

Summary of the general Responsivity factors identified in the therapist treatment experiences literature and the accommodations made within the BNM approach

Negative effects	BNM accommodation
Cognitive: cynical, increased suspicion and mistrust of others, difficulty making decisions, heightened awareness of sexual violence, increased defensiveness, depersonalisation of others, disturbing visual imagery about sexual violence, concern about personal safety, concern about gender identity, questioning beliefs about intimacy, increased rumination, diminished hope, dissatisfaction with organisation.	Careful therapist selection and training. Careful consideration of therapist co working arrangements. Supervision by an experienced therapist. Local monitoring of treatment sessions by the supervisor. Mandatory counselling sessions. Enforced breaks from treatment after a group has finished. Specialist “top up” training courses to encourage resilience in therapists.
Emotional: “Dulled” emotions, emotional hardening, anger, frustration, depression, fatigue, irritability, loss of confidence, fear of own safety, anxiety, helplessness.	Health checks and MOTs. Regular meetings with peer group and local managers. Attendance at national meetings/ working parties.
Behavioural: exhaustion, sleep disturbance, impact on relationship with partner, impact on relationship with children, change in own sexual behaviour, intolerant of others, difficulty feeling and showing empathy for others.	Supervision of therapists.
Positive effects	BNM accommodation
Positive change in offenders; witnessing offender change and wellness	Opportunities to share treatment successes provided in supervision, team meetings, national meetings.
Protecting the public; having meaning, purpose and beliefs; community protection, being at the “cutting edge.”	Opportunities provided to contribute to training events, working parties and national conferences to share good practice.
Professional benefits; personal development, personal growth, sense of achievement,	Opportunities for good therapists to contribute to national training.

5.7 Meeting the general responsivity principle; treatment context

The contextual variables which have been identified within chapter 4.8 relate to the treatment setting, organisational considerations and climate, staff training and support, and the intensity of the treatment provision. The BNM was designed to meet the needs of both community and custody providers. As part of the treatment design process, however, opportunities to provide support and make links with other agencies who play a role in the offender's rehabilitation have been created. For example, Offender Manager and other resettlement staff involvement in treatment sessions. A manual for Offender Managers informing them about the BNM approach has also been developed. The importance of a seamless transition between service providers is recognised. Organisational considerations, including the need for a champion of the approach and the importance of a supportive organisational climate have been highlighted. At a local level within each prison, a management team is established to champion the BNM. This is supported on a national level by a Clinical Lead who has responsibility for the treatment approach across NOMS. Staff awareness briefings are held at a local level for all NOMS staff to improve communication and to educate staff about the treatment approach. Serin and Preston (2001) argued that the single most important factor contributing to the successful implementation of any programme is therapist selection and training (the BNM selection and training process is described above in section 4.7). Alongside selection and training, the need to provide support feedback and supervision is considered fundamental (Palmer and Hollin, 2004). As such a system for staff supervision and support is provided within the BNM treatment approach.

The intensity of treatment is monitored as part of the audit of the BNM. Delivery rates vary between three and five two hourly sessions per week. Any cancellations are monitored.

Table 5. 7

Summary of the accommodations made within the BNM design to ensure that the treatment context general responsivity factor is adhered to

General responsivity factor	Accommodation within the BNM treatment design
Treatment context issues;	Local champions of treatment
Treatment setting	National champion of treatment
Organisational considerations	Supervision of therapists.
Staff training and support	Training of therapists.
Treatment intensity	Monitoring of frequency and timings of sessions in audit.
	Monitoring of any missed sessions in audit.
	Careful management of the end of treatment (range of exercises which structure expectations that the group will be ending)
	Involvement of throughcare/ resettlement staff within treatment
	Staff awareness sessions for staff who are not involved directly in the treatment of offenders

Monitoring of the treatment context is a strong focus of treatment delivery at an organisational level within NOMS. Two processes have been established to ensure treatment integrity at the organisational level. These are accreditation and audit.

Accreditation: Accreditation is a system for ensuring that treatment programmes offered to offenders that aim to reduce recidivism have a proper theoretical basis and are designed in accordance with the What Works literature (McGuire, 1995, 2002). Accreditation panels to oversee prison and community-based treatment programmes have to date been set up in England, Scotland, and Canada and are under consideration in several other countries. Accreditation panels set criteria that programmes must meet, such as the need to demonstrate that the targets and methods of the programme have been shown by research to be effective with offender populations. Accreditation also demands that programmes are supported by ongoing monitoring and evaluation, so the danger of programme drift is reduced. Such an approach has been found to increase accountability and ensure that programmes are based on effective theoretical models (Home Office, 2002). In order to test that the BNM treatment design has been applied in a way that is consistent with the principles of effective rehabilitation, the BNM was submitted for

accreditation by the Correctional Services Accreditation Panel (CSAP). The CSAP accredits programmes which are designed to reduce re-offending. It is comprised of a group of experts from around the world. It uses an evidence based approach to assess programmes against a set of accreditation criteria based on the lessons learnt from international research about what works in reducing re-offending. To be accredited, a programme must demonstrate that it meets 10 criteria which are summarised below:

- A clear model of change: There must be an explicit model to explain how the programme is intended to bring about relevant change in offenders. Its rationale must be explicit and supported by evidence.
- Selection of Offenders: There must be a clear specification of the types of offender for whom the programme is intended, and the methods used to select them.
- Targeting a range of dynamic risk factors (otherwise known as criminogenic needs): A range of dynamic risk factors known to be associated with re-offending must be addressed in an integrated manner within the programme.
- Effective methods: There must be evidence to show that the treatment methods used are likely to have an impact on the targeted dynamic risk factors.
- Skills orientated: The programme must facilitate the learning of skills that will assist participants in avoiding criminal activities and facilitate their involvement in legitimate pursuits.
- Sequencing, intensity and duration: The amount of treatment provided must be linked to the needs of programme participants, with the introduction of different treatment components timed so that they complement each other.
- Engagement and motivation: The programme must be structured to maximise the engagement of participants and to sustain their motivation throughout.
- Continuity of Programmes and Services: There must be clear links between the programme and the overall management of the offender, both during a prison sentence and in the context of community supervision.

- Process Evaluation and Maintaining Integrity: There must be provision to monitor how well the programme functions, and a system to modify aspects of it that are not performing as expected.
- Ongoing Evaluation: There must be provision to evaluate the efficacy of the programme.

In order to satisfy these 10 criteria, the BNM approach is documented via a series of manuals which are submitted as part of the accreditation process. The manuals include; the treatment manual which outlines how the treatment will be delivered, the selection procedure which describes how therapists will be selected, the training manual which outlines how therapists will be trained in the treatment approach, the assessment and evaluation manual which outlines how participants will be assessed and describes how the programme will be evaluated, and a management manual which describes how the programme will be managed on a daily basis. The BNM programme achieved provisional accreditation in 2009 and permission was received to pilot treatment delivery subject to review in 2011. As part of the review process, the results of this research were presented to the CSAP. Full accreditation was received in 2011.

The manuals required for accreditation outline the treatment approach and the requirements for delivery. There has been some debate in the past about the usefulness of manuals in treatment. There are some opponents to the manualisation of treatment by those who suggest that it stifles therapist creativity (Hollin, 2006). But, given that the sex offender treatment is lengthy (approximately 200 hours), and is delivered across multiple sites by multi disciplinary teams, Mann (2009) has argued that manuals are needed to keep treatment focused upon criminogenic needs. Mann observed that this function is particularly important in therapeutic work where the key targets of treatment are not always evident, and where, as reported by Mann, Carter and Thornton (2011), “correctional quackery” may mislead treatment providers into using treatment targets which have been shown to be unrelated to risk. Manuals, which identify the key issues for a treatment programme can help to ensure that treatment remains focused upon the issues that matter. Indeed, Andrews and Bonta (2003) have presented data on the mean effect size

of treatment by indicators of integrity of implementation. They showed a significant and strong correlation between the presence of a manual and the effect size of the programme. In designing the BNM approach, it was important that the manuals were written clearly to enable quality delivery which is consistent with the RNR principles.

Audit: In order to ensure that all treatment sites adhere to the requirements specified within the programme manuals, each treatment site is audited annually by staff from Operational Services and Interventions Group (OSIG), the department responsible for implementation of BNM and other programmes. This auditing process measures the quality of delivery of programmes against a series of implementation criteria. These criteria relate to all aspects of treatment planning, delivery and continuity.

There are two parts to the auditing process; one part considers operational matters, the other clinical matters. Operationally, auditors review the level of institutional support (facilities, staff attitudes, environment); the management of the treatment (supervision, training, assessment); and the continuity and resettlement factors (ensuring progress made in treatment is reinforced and taken forward during the remainder of the sentence and on release). Clinically, auditors review the quality of treatment delivery. This review involves monitoring a sample of the recorded treatment sessions, reviewing the monitoring notes made by the supervisor, reviewing the supervision notes, reviewing all of the materials produced by the group members in treatment and the risk reports produced locally which outline treatment progress in relation to the identified criminogenic needs. Clinical audits are checked by CSAP members to ensure that the auditing has been carried out in a fair and consistent way. The results of the operational and clinical audits are combined to give a total audit score which demonstrates the level of adherence to the accreditation standards. Adhering to these standards ensures that the treatment is in adherence with the principles of effective rehabilitation. All sites receive an audit report each year which describes their progress in relation to the audit criteria. Certain standards have to be achieved. Failure to reach the standards

can, and has, resulted in the withdrawal of financial support for treatment and the subsequent closure of the programme. It is therefore vital that treatment staff adhere to the specifications outlined within the manuals which were agreed as part of the accreditation process. All programmes are subject to biannual review by the CSAP to ensure that programme content and delivery is always in line with the latest research.

In summary, the accreditation and audit processes have been established to ensure that all offending treatment programmes are delivered in adherence with the principles of effective rehabilitation. That is they exist to ensure that offending behaviour programmes are designed and delivered in such a way that a reduction in reoffending is achievable. There are three stages to this process which ensure high quality treatment delivery. The BNM programme is subject to these stages in the same way that all other treatment programmes are. Table 5.8 summarises the 3 stage process.

Table 5.8

Summary of the accreditation and audit process

Stage 1: Accreditation by the CSAP. All treatment must be accredited. The accreditation standard signals that the programme is designed in such a way that it adheres to the principles of effective rehabilitation.

Stage 2: Annual operational and clinical audit by an external audit team. All treatment sites are audited annually to ensure that the treatment being delivered is in line with accreditation standards.

Stage 3: Annual review of audit and biannual review of the treatment programme by CSAP. A sample of the clinical materials from treatment are reviewed annually to ensure that the clinical auditors are monitoring the audit process effectively. A biannual review of all accredited programmes is undertaken annually to ensure that the treatment is up to date and in line with the latest research relating to effective delivery.

5.8 Meeting the specific responsivity principle.

The specific responsivity factors are outlined in chapter 4.15 of this thesis. The factors which have been identified from the treatment outcome literature include motivation, denial, various

demographic and individual factors. The main method for ensuring that the specific responsivity principle is met is the careful selection of group members. Each offender is assessed for suitability in relation to the specific responsivity factors prior to treatment starting. This interview/assessment focuses on motivation to change, denial of offending, mental health and consideration of psychopathic traits.

Motivation to change/ denial: The BNM is designed to accommodate those who are in partial stages of denial. It is not essential for participants to be completely open or indeed fully motivated to make changes to their lives at the start of treatment. BNM treatment incorporates motivational exercises which are designed to engage treatment participants. Total denial of offending, however, would be a barrier to entry.

Demographic characteristics: BNM is only available to male offenders. It is offered in both adult and young offender (age 18 – 25) establishments. As such, young offenders in a young offender institute will be treated separately from adults. Offenders usually transfer to the adult system at the age of 21, but this does vary depending on demand for places. In an adult establishment, treatment would be provided to all men over the age of 21 together. In allocating men to groups, wherever possible an ethnic minority offender is never placed in a group without another ethnic minority offender. Groups contain a mixture of child and adult offenders. They also contain a range of IQ levels.

However, demand for places on the BNM is high and treatment places are scarce. Ideally, group membership would reflect a representative sample of offenders in terms of ethnicity, IQ, age, and offence type. However, practical considerations might influence decisions about suitability and prioritisation of treatment. These considerations include the need to prioritise places to those who have been waiting longest, to those who are most likely to reoffend, to those who are due for release and so forth. As such, despite good intentions to accommodate these

factors, practical necessities (and the likelihood of legal proceedings) may influence adherence to this factor.

Individual factors: Another important variable which is considered at the selection stages is the offender's emotional and mental well-being. Although personality disorders or current mental health instability are not automatically barriers to attendance on treatment, a full understanding of how these needs may manifest in group work is needed so that treatment teams have a full understanding of how this might impact on group work. The level, nature and combination of psychopathic traits demonstrated by the individual are also considered. Thought is given to whether these traits are likely to interfere with engagement or ability to benefit from the programme. All IDSOs are screened for mental health issues prior to treatment starting. Men are selected out if their mental health is unstable, or if the health professionals perceive that treatment might impact their mental health in a negative way.

In summary therefore, the specific responsivity factors identified in the literature are accommodated by careful selection procedures, training and flexible delivery options. This has been summarised in table 5.9 below. The suitability assessment ensures that the specific responsivity factor is adhered to within BNM.

Table 5.9

Summary of the specific responsivity factors and their accommodation within the BNM treatment programme design

Specific responsivity factor	BNM accommodation
Motivation	Careful selection of group members Training Flexible delivery options
Denial	Careful selection of group members Training Flexible delivery options
Demographic variables	Careful selection of group members Training Flexible delivery options

5.9 Conclusions

In this chapter, the development of the BNM sex offender treatment programme in line with the available evidence (described in chapters 2, 3 and 4) has been outlined. More specifically, the adherence of the BNM approach to the RNR principles has been described. The treatment approach has been validated by the Correctional Services Accreditation Panel who have confirmed that the programme is likely to be effective based on what is known internationally about treatment effectiveness and impact. However, even the best designed treatment approach can lead to negative or minimal treatment success. In order to establish whether or not the BNM is effective, and thereby to further the knowledge base about the treatment of IDSOs, there is a need to evaluate treatment impact. In chapter 6, a research design which involves both an outcome and a process evaluation of the BNM approach is described.

Chapter 6: Introducing the research

This thesis aims to advance our understanding about the assessment and treatment of IDSOs. The RNR model has been shown to be a useful rehabilitation model for the treatment of non ID offenders, including sexual offenders (see chapters 1 – 4). Yet its applicability to IDSOs is largely untested.

The research question of this thesis is; can the RNR model be successfully applied to the treatment of IDSOs? The BNM treatment programme was designed to meet the principles of RNR (see chapter 5). Indeed, its design has been recognised to reflect the standards of best practice by the CSAP. How successful has it been?

6.1 How successful is the BNM approach in adhering to the Risk principle?

The BNM targets medium, high and very high risk IDSOs as assessed by RM2000/s (lower risk IDSOs are not treated via BNM). In order to be successful, the BNM programme must lower the level of needs for all three of these risk classifications. Therefore, it is hypothesised that all participants on the BNM will achieve positive change regardless of their risk classification.

Further, a treatment approach is only successful if participants stay in treatment. The literature shows that a participant's risk of reoffending can be increased if he fails to complete treatment. The research will examine the BNM non completers to see what lessons can be learnt.

6.2 How successful is the BNM approach in adhering to the Need principle?

The aim of the BNM intervention is to lower recidivism. It is not possible to measure recidivism at this time given that this is a new intervention. According to the literature, there is a relationship between reduced levels of criminogenic needs (as measured by psychometric assessment) and recidivism. As such, in order to establish the effectiveness of the BNM, the outcome study will test whether the level of criminogenic needs of the BNM participants is lowered post treatment.

Thanks to Thornton (2002) and Mann, Hanson and Thornton (2010), sex offender treatment providers now have a sound base of knowledge about the criminogenic needs (Sexual interests, offence-supportive attitudes, socio-affective functioning, and self-management) of those who commit sexual offences (see chapter 3 for full details). Yet, as Lindsay (2002) observed, there is a lack of available psychometric tools specifically designed to measure the criminogenic needs of IDSOs. A battery of assessment measures was developed to assess the needs of IDSOs for the BNM programme. These measures were either developed specifically for this purpose or adapted from existing measures. As such, there is a need to establish the psychometric properties of each measure.

The effectiveness of the new BNM measures are tested in two ways. Firstly, the reliability and construct validity of each measure are established. Only reliable and valid measures will be used in the outcome evaluation. Second, the psychometrically robust measures were used pre and post treatment to determine if BNM participant's levels of criminogenic needs had changed. It was hypothesised that participants responses on the measures would change in the desired direction post treatment.

6.3 How successful is the BNM approach in adhering to the Responsivity principle?

There are two types of responsivity. General responsivity calls for treatment to be delivered in a way which enables the learning of the target group. It relates to general factors which apply to all group members. Specific responsivity specifies that the approach should be tailored to the individual in treatment. That is, any factors that are relevant to an individual in a group, should be accommodated for within treatment delivery. There are four general responsivity factors.

Treatment approach; CBT has been identified as the most useful treatment approach for sexual offenders and there is some research to support the use of CBT with IDSOs. However, the literature is clear that adaptations to the CBT approach are needed in order to enable IDSOs to

benefit from treatment. The BNM approach was developed in line with the adaptations recommended in the literature.

Group environment; The literature suggests that group cohesion plays an important role in treatment. It appears that a closed group format for 6 – 8 participants is most likely to contribute to successful outcome. The BNM approach has been designed accordingly.

Therapist characteristics; It is clear that the therapist plays a critical role in treatment. Successful characteristics of the therapist have been identified. The selection and training of therapists is an important part of the BNM approach. Further, support systems have been put in place to ensure that these characteristics are maintained.

Treatment context; the impact of contextual factors in treatment has previously received little attention, especially in relation to IDSOs. Yet, as a group they are likely to have suffered stigmatisation and shame throughout their lives. In the Criminal Justice System, their needs have been largely ignored, indeed they have not even been recognised as ID as NOMS does not routinely screen offenders for ID. In order to determine the success of the BNM approach it is important that the IDSOs feel supported and safe in treatment. The BNM approach enables this by a) identifying this group, b) providing opportunities for treatment, c) selecting and training suitable therapists to facilitate treatment.

The literature is sparse in relation to specific responsivity. IDSOs are a diverse group who have a wide variety of characteristics and associated needs. Given that specific responsivity factors are individual, and that differences between individuals are likely to exist, it is not possible to predict all of the specific responsivity factors which will apply. As such, it is important that some degree of flexibility is built into the treatment design to enable responsive delivery for each individual in treatment.

How will the success of the BNM approach in relation to responsivity be determined? Responsivity is the least researched of the RNR principles; even the sex offender literature base is weak and the IDSO literature base is virtually non-existent. It is likely that there are a number of factors which to date have not been identified for this group. In order to advance our understanding of this principle, a qualitative investigation was planned. Focus group discussions with BNM participants were designed. Given that all participants had completed treatment, they were familiar with group working and as such this approach was considered to be appropriate. The literature relating to responsivity has to date always been described from the participant's point of view only, yet the literature review revealed that the therapist plays a crucial role in treatment. In order to ensure their success in treatment, it is important that responsivity factors which affect their performance are accommodated for. As such, focus group discussions with BNM therapists were also planned.

The main objectives of the process evaluation were: a) to elicit views about the effectiveness of the BNM treatment approach, b) to elicit views on the group environment, c) to elicit views on the therapist characteristics, d) to elicit views on contextual factors, e) to elicit views on the personal impact of treatment, f) to bring the information together in a summary of the key responsivity factors affecting treatment experience, supported by evidence from the research.

In order to determine the success of the BNM approach in relation to the specific responsivity principle, the factors which have been identified as particularly relevant to IDSOs in treatment; IQ level, age and offence type were examined in relation to treatment outcome. It was hypothesised that; a) all participants on the BNM will achieve positive change regardless of their risk classification, b) all participants will achieve positive change in treatment irrespective of their IQ level, c) all participants will achieve positive change in treatment irrespective of their age, d) all participants will achieve positive change (as appropriate) in treatment irrespective of their offence type.

6.4 Summary

A summary of the research aims/ hypotheses and questions and plans to determine the successfulness of the programme in relation to Risk, Needs and Responsivity is provided in Table 6.1 below. Taken together, the research will determine whether the RNR approach has been successfully applied in the treatment of IDSOs. The results of this research will provide a significant contribution to the literature in terms of helping us to understand more about the assessment and treatment of IDSOs.

Table 6.1

Summary of the research aims and plans to determine treatment success.

	BNM approach	Approach approved by CSAP?	Research aims/ hypotheses/ questions
Risk	Identification of risk level using RM2000/s Treatment only offered to Medium, High and Very High risk men.	Yes	There will be no significant difference between the risk groups in terms of treatment success.
Need	Identification of relevant criminogenic needs for IDSOs Development of a treatment approach which targets the criminogenic needs of IDSOs.	Yes	A battery of assessment measures will be developed. Psychometric properties will be determined. Treatment participants will show change in the desired direction on all of the measures as a result of BNM
Responsivity	Possible responsivity factors identified in the literature review Treatment designed to reduce the influence of the identified responsivity factors	Yes	All participants will show change in the desired direction regardless of IQ level, age, or offence type Focus group respondents will not report identified responsivity factors to be problematic in BNM

Chapter 7: The development of measures to assess the criminogenic needs of IDSOs

7.1 Introduction

It is important when adapting measures from the mainstream sexual offender literature to a different population, or when developing new assessments that the psychometric properties of the test are established (Kroner and Weekes, 1996; Lindsay, 2002). This chapter explains the research design, the methodology and the measures that form the BNM assessment battery; the adapted self esteem questionnaire, the adapted impulsivity scale, the adapted ruminations scale, the adapted relationships style questionnaire, the adapted openness to women scale, the adapted openness to men scale, the sex offender's opinion test and the My Private Interests Measure. This chapter also outlines how the measures were adapted to meet the needs of the IDSOs. This study aimed to establish the psychometric properties of the measures in terms of their reliability and construct validity. One hundred and thirty one IDSOs participated in the study. Demographic information was also obtained.

7.2 Design

This research project involved all of the 9 treatment sites which offered BNM between July 2009 and April 2011. Some sites ran more than one group, so in total this sample is drawn from 17 treatment groups. The prisons were spread across England and Wales and reflected a range of different custodial establishments from young offender institutions to maximum security prisons. The men attending treatment were all located in sex offender or vulnerable prisoner wings within the prisons, separated from other offenders. ID and non ID sexual offenders are located together. Indeed, unless the men are being assessed for or attending treatment, it is unlikely that staff are aware of their ID, there is no routine assessment or screening for ID in custody (or in the community).

Many of the men in prison have complex and multiple criminogenic and other needs. Their criminal history is often diverse and multifaceted. HM Prison and Probation services offer a range of treatment options for offenders to meet their varied needs. There are, for example, treatment programmes which target criminal thinking, substance misuse, managing anger and so forth. All of the approaches have been developed for mainstream offenders only and are written for men with IQs above 80. Nevertheless, because these are the only treatment options available across NOMS, many IDSOs attend these programmes. It is recommended policy that general criminogenic needs are targeted and addressed before more specific criminogenic needs, and as such most sexual offenders will attend non ID general criminogenic treatment approaches such as thinking skills programmes, before they are referred for sexual offender treatment. IDSO men who attend mainstream treatment programmes oftentimes do not complete successfully and are found to be difficult to manage. So, for many IDSOs, whose needs are only properly catered for by an adapted treatment approach, there have already been experiences of confusion/ anxiety/ failure as a result of attending a criminogenic treatment programme in prison.

In the Prison system when a sexual offender is identified as needing treatment and is received into an establishment which offers sex offender treatment (of which there are 26 across the Prison estate), he will be offered the opportunity to be assessed for treatment. At this stage, it is not known whether or not the offender has an intellectual disability, so in the main, it is expected that he will be considered for a mainstream treatment approach (Of the 26 sex offender treatment sites, only 9 offer adapted treatment for IDSOs). If an offender consents to being assessed for treatment, a file and medical review is undertaken. Those deemed suitable medically (not actively psychotic or suicidal), and whose legal status was in line with treatment (they were not actively appealing against their conviction), were assessed using a screening assessment of intellectual functioning. As it is rare that treatment is refused on medical and/ or legal grounds, most of those volunteering to attend treatment will be forwarded for assessment. At this point, if the offender's

IQ falls lower than the cut off for mainstream treatment (IQ<80), he would be assessed for the adapted treatment pathway. Further assessments for the BNM approach will often therefore necessitate a transfer from one prison to another in order to access the specialist resources required for BNM delivery. All men who are assessed as suitable for treatment will receive treatment, there are no grounds for excluding men on the basis of assessment information. The IQ level of those who do not consent to be assessed for sex offender treatment is unknown. As such, it is not possible to explore whether this group are different in significant ways to the population used in this study. Since offenders are not screened for ID, there is no way of knowing how many IDSOs refuse treatment.

7.3 Ethical considerations

Before commencement of this research, ethical approvals were obtained from Roehampton University and NOMS.

When designing any treatment intervention or conducting any research, it is essential that meticulous care is taken to protect the individuals involved. The issue of informed consent is particularly difficult in treatment and research with intellectually disabled individuals (Arscott, Dagnan and Sternfert-Kroese, 1998). The Mental Capacity Act (2005) dictates that in order to have capacity to consent a person must: (i) understand, when explained in language comprehensible to most, what the treatment/ research is, its purpose and nature and why it is being proposed; (ii) understand its principle benefits, risks and alternatives; (iii) understand in broad terms what will be the consequences of not taking part in the proposed treatment/ research; and finally (iv) retain the information long enough to make an effective decision and make a free choice. Given the complexity of this undertaking, due care and attention is needed to ensure that a) each individual is has the capacity to consent, and b) that those deemed to be capable of consent are provided with suitable and appropriate information about what they are consenting to.

Assessing capacity to consent: The assessment of capacity to consent is an important concern for any treatment intervention or indeed for any research project. In order for an individual to consent, he/ she needs to be able to meaningfully discuss the suggested treatment option and understand how he/ she is likely to change with or without it. Bellhouse et al (2001) recommended a number of strategies to improve capacity to consent in relation to various medical situations. The application of these strategies to treatment and research contexts is outlined below.

7.4 Consent procedures on the BNM

In order to enable effective decision making amongst this client group a “functional approach” to assessing capacity was undertaken (Murphy and Clare, 2003). This approach advocates that a person’s capacity to consent should be assessed at the point in time when a particular decision is needed. For all men volunteering to attend the BNM, there are 2 stages to the consent process. Firstly, all men are asked to give their consent to assessment for BNM. This individual interview takes place prior to any assessment or treatment taking place. In this interview the participants’ expectations are structured around what to expect during the assessment process. He is also informed about how the results will be used and is told that his results will be held on a central database for research purposes. Subsequently, in a separate interview prior to treatment starting, all participants are asked to consent to the BNM treatment programme itself.

A person with an intellectual disability has the right to receive information that s/he can understand, and which takes account of their individual circumstances, such as level of understanding, reading ability, and knowledge about treatment/ research and treatment/ research requirements. Morris *et al.*, (1993), Arscott *et al.*, (1999) and Dye *et al.*, (2004, 2007) stress the importance of considering the following characteristics when establishing consent in clients with ID; verbal and memory abilities; difficulties with problem solving; tendency towards acquiescence and suggestibility and problems with concreteness and abstracting from examples; difficulties processing complex sentences of information. Acquiescence is also common when individuals do

not understand questions asked of them (Sigelman *et al.*, 1981). This is likely to be because of the combined effects of their degree of cognitive impairment and social desirability (Shaw and Budd 1982). People with ID also have difficulties holding information at the sensory registration stage, are slow to analyse information, have difficulties choosing the most relevant information when in a problem – solving situation, and have difficulties with increasing levels of abstractness and generalising from examples (Murphy and Clare 1998). In addition, an individual's receptive language ability can impact on their ability to understand the implications of taking part in an activity (Arscott *et al.*, 1998).

As such, due care and attention has been paid to ensuring that the consent process on the BNM adheres to the recommendations outlined above. All materials were developed in easy read formats accompanied by pictorial images. Verbal explanations were given alongside written/drawn information. Two leaflets were developed; one which outlined what would be involved in the treatment process, the costs and gains, the alternatives, the potential risks of involvement in treatment etc; and a second leaflet which outlined issues in relation to consent to research. It is recognised that people with intellectual disabilities are very valuable advisers on the wording of information sheets and as such information sheets and consent forms were developed and trialled with a group of ID men. All of the research participants had given their consent to both assessment and treatment as part of the BNM approach.

It is important that staff involved in consent interviews are suitably trained. Experienced interviewers are needed to ensure that possible communication, knowledge and reasoning difficulties, and tendency to acquiesce to 'authority figures' are taken into account during decision making. A "supported decision making approach" (Bach and Rock, 1996) is advocated on the basis that individuals are most likely to need someone they trust and have confidence in to help them make their decision. Few individuals have the total capacity to make important rational decisions autonomously. Within this model it is the process of decision-making that must be shown to be

competent rather than the individual. Wherever possible, individuals were interviewed by someone with whom they had a positive connection. There is an emphasis on encouraging an honest and open discussion about the consequences of taking part/ not taking part in treatment/ research. The circumstances should be “free from pressure.” In the community, men routinely find themselves sentenced to treatment, with little opportunity to refuse. In custody, although treatment is voluntary, there are various incentives used (sentence planning, transfer to less secure conditions, parole etc) which mean that there is a pressure to accept treatment. It is important that the interviewer recognises and acknowledges the pressures that the individual may be under. It is important that the interviewer explains fairly (in a way in which the individual will understand) the situation the offender is in. Finally, it is emphasised that an individual is entitled to refuse treatment or be a part of the research strategy, even if this appears to be neither sensible, well considered or even rational.

7.5 Participants

The sample were all 140 adult male sexual offenders who consented to assessment and treatment and were assessed as having an IQ in the 60 - 80 range. 131 men completed treatment between July 2009 and April 2011, 9 men started but did not complete treatment. The participants were all adult (aged 18 or over) male offenders. All of the participants had completed the Becoming New Me Sex offender treatment programme in custody. Sixty four per cent ($N = 84$) of the sample were serving a Life or Indeterminate Sentence for Public Protection (ISPP) sentence.² Prison records showed that 75% ($N=98$) of the sample described their ethnicity as white. Fourteen

² Indeterminate Sentence for Public Protection is a form of indeterminate sentence intended for those whose crimes are not serious enough to merit a normal life sentence, but who are a danger to the public, and so should not be released until the Parole Board decides they no longer represent a risk.

percent ($N= 18$) described themselves as Black, 8% ($N=10$) Asian, 2% ($N= 3$) Mixed and the remaining 2% ($N=2$) did not specify their ethnicity.

7.6 Procedure

In order to be eligible for this research, participants had to be suitable for attendance on the BNM programme. Suitability was determined by a two stage assessment process. Firstly, two baseline measures were completed. Second, a number of dynamic assessment measures were completed prior to treatment starting. All baseline and dynamic assessments were completed pre treatment. For programme evaluation purposes, each individual was also asked pre treatment to provide demographic information. This demographic information covered various topics including the participant's ethnic category, date of birth, sentence type, sentence length, number of previous convictions, and employment history.

The dynamic assessment measures were repeated by all participants approximately 6 weeks post treatment. The time frame for post treatment assessment (6 weeks) is dictated by NOMS resourcing of treatment programmes. This time frame ensures that a full treatment cycle (pre assessment, treatment and post assessment) can take place within one financial year.

Baseline assessment measures: The baseline measures described important characteristics of the men including their likely risk of sexual reconviction and their intellectual disability. The baseline measures are described in table 7.1.

Table 7.1

Baseline assessment measures 1

Assessment of static risk	RM 2000 sex scale (Thornton <i>et al.</i>, 2003)
Intellectual functioning	Wechsler Adult Intelligence Scales (Wechsler, 2008).

Risk Matrix 2000 (RM2000/s) (Thornton et al. 2003): RM2000/s (Thornton et al., 2003) has previously been described in chapter 2.4. The RM2000/s predicts sexual recidivism and is made up of seven items divided into two scoring steps.

Wechsler Adult Intelligence Scales (Wechsler, 2008): The WAIS IV assessment provides an assessment of intellectual functioning. It was released in 2008, and is composed of 10 core subtests and five supplemental subtests, with the 10 core subtests comprising the Full Scale IQ.

Dynamic assessment measures: Dynamic assessment measures are those that measure the criminogenic needs known to be related to sexual reconviction in IDSOs (as has been outlined in chapter 3.3). A battery of 8 measures was used to assess IDSOs.

Table 7.2

Dynamic assessment measures 1

Dynamic assessment measures	
The Adapted Self Esteem Questionnaire	Adapted from Thornton, Beech and Marshall's (2004) Self-esteem Questionnaire to test feelings of inadequacy.
The Adapted Ruminations Scale	Adapted from Caprara's (1986) Dissipation-Rumination Scale to test suspicious, angry and vengeful feelings towards others.
Adapted Relationships Style Questionnaire	Adapted from Dutton <i>et al.</i> , 's (1994) Relationship Style Questionnaire to test an individual's relationship style and desire for intimacy.
Adapted Openness to Women Scale	Adapted from Underhill <i>et al.</i> , 's (2008) Openness to Women scale to test an individual's comfort with adult women.
Adapted Openness to Men Scale	Adapted from Underhill <i>et al.</i> , 's (2008) Openness to Men scale to test an individual's comfort with adult men.
Sex Offenders' Opinion Test (SOOT)	This questionnaire originated from Bray (1997). It was developed for IDSOs to test child abuse supportive beliefs and beliefs that women can not be trusted.
My Private Interests Measure (MPI)	This assessment was developed by Williams (2007) for use with IDSOs to test the sexual interests and preferences.

Six of the eight measures were adapted from assessments developed for mainstream sexual offenders. The SOOT was originally developed by Bray (1997) and refined following psychometric

analysis as described in Williams *et al.*, (2007). The MPI was developed specifically for use with the current population by the researcher.

7.7 Developing the adapted assessment measures.

Where necessary, approval was obtained from the original authors of the assessments to adapt a measure for use with this client group. A number of procedures have been recommended in the adaptation of self-report assessments, such as shortening sentence length, simplifying vocabulary and removing ambiguities (Kolton *et al.*, 2001; Ley and Florio, 1996). During the adaptation process, the researcher firstly consulted with a group of experienced staff to identify the potential sources of difficulty with the original measures. The staff were all experienced at working with IDSOs. This information was then used this information to adapt each test. After the adaptation process was complete, the researcher once again consulted the experienced staff to assess any discrepancies between the content of the original and adapted versions that might have arisen through the process of adaptation. The issues identified led to further discussion and refinement of the adaptations.

Each of the measures was adapted from a paper and pencil task to a series of questions to be asked as part of an interview. Wherever possible, the number of items in the measures was reduced so that the total length of the assessment process could be reduced. It is widely reported that IDSOs struggle to concentrate for long periods of time and so this was a consideration in the adaptation process. The phrasing of the questions posed was changed to make the questions simpler to understand. The vocabulary used was also simplified and any ambiguous or complex terms or statements were removed. All of the questions were written in everyday language. Likert scales were abandoned in favour of simple yes/ no responding in all of the measures bar the SOOT where an interactive game method was used to help understanding. Each of the questions in the SOOT was printed onto a card which was read out by the administrator. Participants signalled their agreement with the statement by posting their response into a box. Five boxes were used to

represent a Likert scale. Each box represented a level of agreement with the statement ranging from strongly disagree to strongly agree. Thumbs up and down symbols accompanied the written text to signal level of agreement/ disagreement. In describing the measures, any information relating to reliability and validity of the assessments is provided when this is available. ³

7.7.1 The Adapted Self Esteem Questionnaire

This questionnaire is an adapted version of Thornton, Beech and Marshall's (2004) 8 item self-esteem questionnaire. Items have been reworded using simpler phrasing. Respondents rate on a dichotomous yes/ no scale. Items are summed to give a total score with high scores related to high self-esteem (range 0 – 8). This questionnaire was used as part of the Adapted SOTP (the forerunner to the BNM) and was found to have acceptable internal consistency with Cronbach alpha as .77 ($N = 211$) (Williams, Wakeling and Webster, 2007). Williams *et al.*, conducted a principal components analysis which produced one unitary component with an eigenvalue of greater than 3, explaining 38.4% of the variance. Examination of the scree plot supported the extraction of one component. Given the previously identified reliability of this assessment, it was chosen to assess levels of self reported self esteem in the BNM assessment battery. Feeling inadequate is a risk factor associated with sexual reconviction and it is hypothesised that those with higher levels of self esteem are less likely to feel inadequate.

7.7.2 The Adapted Impulsivity Scale

This scale is an adapted version of Eysenck and Eysenck's (1978) 13 item Impulsivity Scale. It reflects a tendency to act without thinking about long-term consequences. Respondents rate on a dichotomous yes/ no scale. Items are summed to give a total score with high scores related to high

³ The BNM assessment measures can not be included within this thesis due to the restricted nature of this material. Permission to use these materials can be requested by contacting Dr. Adam Carter, Head of SOTP, 4th Floor, NOMS, 77 Petty France, London, SW1H 9EX.

impulsivity (range 0 – 13). Nine items (items 1, 2, 3, 4, 5, 8, 9, 10 and 13) are adapted from Eysenck and Eysenck' (1978) scale using simpler wording. The remaining 4 items were developed by the researcher after discussion with colleagues as noted. This assessment measure was chosen as a measure to test impulsive and unstable lifestyle which is a risk factor which has been associated with sexual reconviction.

7.7.3 The Adapted Ruminations Scale

This is a 15 item scale adapted from Caprara's (1986) Dissipation-Rumination Scale. All items are derived from Caprara's scale, though most are reworded. Caprara's original scale had 20 items. Five of Caprara's items were not included in the Adapted Ruminations Scale. This scale measures a tendency to ruminate angrily and bear grudges. Respondents rate on a dichotomous yes/ no scale. Items are summed to give a total score with high scores related to greater rumination (range 0 – 15). This assessment was chosen to test suspicious, angry and vengeful feelings towards others which have been identified as a risk factor associated with sexual reconviction.

7.7.4 The Adapted Relationships Style Questionnaire

This questionnaire is an adapted version of Dutton *et al.*'s (1994) Relationship Style Questionnaire. The original RSQ is a 30-item questionnaire used to measure relationships styles and attachments. The adapted version of the scale uses simpler wording than the original. Additionally, the adapted version uses a yes/no response rather than a 5-point Likert scale. Respondents rate on a dichotomous yes/ no scale. For scoring purposes, two of the items are removed and eight items are reversed. Scores range from 0 to 28. This assessment was chosen to assess an individual's relationship style and desire to have an intimate relationship. Lack of intimate relationship with another adult is a risk factor associated with sexual reconviction.

7.7.5 The Adapted Openness to Women Scale

This questionnaire is an adapted version of Underhill *et al.*'s (2008) 9 item openness to Women scale. It has been reworded using simpler phrasing. This scale measures openness or emotional congruence with women. The response form has been changed to yes/ no, as opposed to a Likert scale which is used in the original version. Items are summed to give a total score with high scores related to belief that he is able to have and enjoys emotionally intimate relationships with women (range 0 – 9). Four items are reverse scored. This assessment was chosen to assess the individual's comfort with adult women. Feeling more comfortable with children than adults is a risk factor associated with sexual reconviction.

7.7.6 The Adapted Openness to Men Scale

This questionnaire is an adapted version of Underhill *et al.*'s (2008) 9 item openness to Men scale. It has been reworded using simpler phrasing. This scale measures openness or emotional congruence with men. The response form has been changed to yes/ no, as opposed to a Likert scale which is used in the original version. Items are summed to give a total score with high scores related to the respondent's belief that he is able to have and enjoys emotionally intimate relationships with men (range 0 – 9). Four items are reverse scored. This assessment was chosen to assess the individual's comfort with adult men. Feeling more comfortable with children than adults is a risk factor associated with sexual reconviction.

7.7.7 The Sex Offenders' Opinion Test (SOOT)

This questionnaire originated from Bray (1997) who developed the assessment specifically for use with IDSOs. The Sex Offenders Opinion Test (SOOT) is a 20-item instrument, which measures attitudes about victims of sexual offences. Respondents rate each statement on a five-point Likert scale, ranging from 1 = strongly disagree, through to 5 = strongly agree. Items are summed to produce a total scale score, higher scores relating to higher distortions about victims of sexual offences. The SOOT comprises two sub-scales, 'Deceitful Women and Children', and 'Children, Sex

and the Law'. Sub scales are scored separately by summing corresponding items. Total range of scores is 20 to 100. "Deceitful Women and Children" range is from 15 to 75, "Children, Sex and the Law" range is from 5 to 25. The internal consistency of Deceitful Women and Children has been reported as .80 ($N = 211$), as was the internal consistency of Children, Sex and the Law at .83 ($N = 211$) (Williams *et al.*, 2007). Given the previously identified reliability of this assessment, it was chosen to test child abuse supportive beliefs and beliefs that women can not be trusted. These attitudes are known risk factors for sexual recidivism.

7.7.8 My Private Interests Measure (MPI)

This assessment was specifically developed by the researcher for use with IDSOs. It is a 54-item scale measuring sexual interests. The scale covers a variety of different areas of 'interests' and provides an overall picture of participants' sexual interests. Respondents rate on a dichotomous true/ false scale, whether or not they agree with the statement. Two items are reverse scored. Items are summed to give a total score with high scores related to greater number of "interests" (range 0 – 54). The MPI was chosen to test the sexual interests and preferences of IDSOs. In particular it tests the risk factors known to be strongly associated with sexual offending; sexual preoccupation, a sexual interest in children, a sexual interest in violence and humiliation and other paraphilia.

7.8 Administration of the adapted assessment measures

All assessments were undertaken locally at each of the treatment sites by trained staff. RM2000/s assessments were scored by specially trained assessors. The WAIS IV and all of the dynamic assessments were administered as interviews individually. All administrators received training in undertaking assessments. This training included all aspects of the administration process, from building rapport to ensuring consistency in test administration. Administrators recorded all responses on an answer sheet. Simple prompts were given as necessary to enable understanding if any item was unclear. Wherever possible the same administrator was used pre

and post treatment. The administration of all psychometrics took place under the supervision of a Chartered and registered Psychologist. Once completed, all data was collated into a central database.

7.9 Analysis

Testing reliability: The reliability of a scale indicates how free it is from random error. This is usually tested in two ways; test retest reliability and internal consistency. The test retest reliability of a scale is assessed by administering the scale to the same people on two different occasions and calculating the correlation between the 2 scores obtained. High test retest correlations indicate strong reliability. This type of reliability is especially useful for scales which measure stable characteristics such as personality, and not useful for scales which measure temporary states such as mood. This methodology is also resource intensive and therefore costly. Administration of scales on two separate occasions requires a significant time commitment. Given that all of the BNM assessments require one to one administration, and that on average completing the dynamic assessment measures with an individual amounts to approximately 4 hours of administrator time (plus scoring and interpretation), it was not feasible to undertake test retest reliability on the assessments within this battery.

The second aspect of reliability that can be assessed is internal consistency. This is the degree to which the items that make up the scale are all measuring the same underlying attribute. The internal consistency of the questionnaires was measured using Cronbach's alpha coefficients. Cronbach's alpha coefficient is a measure of how well a set of items measure a single uni-dimensional latent construct, and this is referred to as the internal consistency or reliability of a questionnaire or the set of items comprising a single subscale within a larger measure. It is generally accepted that a value of 0.70 is the lowest acceptable measure of unity, and that values are more acceptable as they become closer to the value of 1.0 (Kline, 1998), as this reduces the extent of any measurement error. Additionally, the value of Cronbach's alpha coefficients tend to

increase with the addition of extra items. However, in batteries of questionnaires there is a trade-off between increased reliability at the expense of an excessive number of items that is no longer readily manageable for the individual. This is a particular consideration for IDSOs who struggle to focus and concentrate for long periods of time. The internal consistency of all of the BNM assessments was calculated using Cronbach's Alpha coefficient calculations.

Testing construct validity: The validity of a scale refers to the degree to which it measures what it is supposed to measure. There are a number of different types of validity. In this study, the focus was on establishing the construct validity of the assessments used in the BNM assessment battery. Construct validity reflects the ability of an assessment to measure an abstract concept or construct. Construct validation occurs where the measure under investigation provides results that are consistent with the hypothesised theory about a concept or construct. In relation to this study, it was important to ensure that each of the BNM assessment measures assessed the construct it intended to assess.

In order to ensure that the BNM measures were assessing the specific variables of interest (i.e. the criminogenic needs of IDSOs), principal components analysis (PCA) was undertaken. PCA provides an "empirical summary of the data set" (p664 Tabachnick and Fidell, 1996). Throughout the analysis, varimax rotation method was employed where required. Varimax is an orthogonal method of rotation which assumes that the factors are not correlated. Costello and Osborne (2005) note that rules regarding sample size for exploratory factor analysis have mostly disappeared. Studies have revealed that adequate sample size is partly determined by the nature of the data (Fabrigar *et al.*, 1999; MacCallum, Widaman, Zhang, and Hong, 1999). In general, the stronger the data, the smaller the sample can be for analysis. "Strong data" is defined as uniformly high communalities (.8 or greater Velicer and Fava, 1998) without cross loadings, plus several variables loading strongly on each factor. Unfortunately, these conditions are rare (Mulaik, 1990; Widaman, 1993). Costello and Osborne advise the following if more common low to moderate communalities of .40 to .70 are observed:

a) If an item has a communality of less than .40, it may either a) not be related to the other items, or b) suggest an additional factor that should be explored. The researcher should consider why that item was included in the data and decide whether to drop it or add similar items for future research.

b) Tabachnick and Fidell (2001) cite .32 as a good rule of thumb for the minimum loading of an item, which equates to approximately 10% overlapping variance with the other items in that factor.

c) If an item loads at .32 or higher on two or more factors, a “crossloading item”, the researcher needs to decide whether it should be dropped from the analysis or not. This may be a good choice if there are several adequate to strong loaders (.50 or better) on each factor. If there are several crossloaders, the items may be poorly written or the a priori factor structure could be flawed.

d) A factor with fewer than three items is generally weak and unstable; 5 or more strongly loading items (.50 or better) are desirable and indicate a solid factor. With further research and analysis it may be possible to reduce the item number and maintain a strong factor; if there is a very large data set.

7.10 Results

The psychometric properties for each of the assessment measures will be presented in turn.

7.10.1 The adapted self esteem questionnaire

The Cronbach Alpha coefficient was .81 ($N=128$) pre treatment, and .82 ($N=130$) post treatment. The 8-item measure had good internal consistency at both the pre and post treatment stages. Removing one item (item 5) improved the internal consistency to .82 pre treatment and .83 post treatment.

Principal components analysis revealed the presence of one factor with an eigenvalue exceeding 1, explaining 42.83% of the variance in the data. Inspection of the screeplot revealed a clear break after the first component confirming that the scale is composed of one component. On closer inspection of the component matrix, all questions load strongly ($>.4$) on the single component, except item 5 which has a poor loading (.3). As noted above, removal of this item improved the internal consistency of the scale. However, given that this is an 8 item scale and the fact that the items relate to each other clinically, it was decided to retain all items within the one factor solution. The factor loading for each question on this single factor is reported in table 7.3.

Table 7.3:

Factor loadings for all items on the adapted self esteem questionnaire.

Item	Component 1
Q2: Do you like the sort of person you are?	.803
Q7: Are you pretty happy with the way you are?	.744
Q4: Do you understand yourself?	.706
Q8: Do you have a low opinion of yourself?*	.651
Q1: Do you often wish you were someone else?*	.641
Q6: Are things all mixed up in your life?*	.641
Q3: Do you often feel ashamed of yourself?*	.623

*denotes items that are reverse scored

This single factor supports the use of the full scale without factors as reported in previous research (Williams *et al.*, 2007). The adapted self esteem scale is psychometrically reliable and valid for use with IDSOs.

7.10.2 The adapted impulsivity scale

The Cronbach Alpha coefficient was .83 (N=128) pre treatment and .85 (N = 131) post treatment. The 13-item measure had good internal consistency at both the pre and post treatment stages. Removing one item (item 3) improved the internal consistency to 0.84 pre treatment and 0.86 post treatment.

Principal components analysis revealed the presence of three factors with eigenvalues exceeding 1, explaining 69.1% of the variance in the data. Factor 1 accounted for 39.6% of the variance, factor 2 accounted for 11.6% of the variance and factor 3 accounted for 9.8% of the variance. Inspection of the screeplot revealed a clear break after the third component. Using Cattell's (1966) scree test, it was decided to retain three components for further investigation. On closer inspection of the component matrix, all questions loaded strongly ($>.4$) on component 1. Given that this is a 12 item scale (Item 3 did not load onto any component) and given the reliability results reported earlier, it was decided that item 3 should be removed from any further analysis. As all the items load strongly on one component which explains 39.6% of the variance, and the items relate clinically, it was decided to retain a one factor solution rather than the three factor solution. All subsequent analysis is based on a 12 item scale. The factor loadings for each question are reported in Table 7.4.

Table 7.4:

Factor loadings for all items on the adapted impulsivity scale.

Item	Component 1	Component 2	Component 3
Q1: Do you do and say things without thinking?	.752		
Q5: Do you often speak before thinking?	.740		
Q2: Do you get into trouble because you do things without thinking?	.735		
Q4: Do you do things on the spur of the moment?	.717		
Q13: Do you think carefully before doing things?*	.656	.472	
Q6: Do you often get involved in things you later wish you had not got involved in?	.636		
Q9: Do you need to control yourself so that you don't get into trouble?	.590		.368
Q7: Do you think before you act?*	.550	.482	.305
Q11: When making a decision do you think about the possible good and bad things that could happen?*	.497	.670	
Q12: Do you make your mind up quickly?	.453		-.713
Q8: Do you sometimes get carried away with ideas?	.507	-.435	.511

*denotes items that are reverse scored

The adapted impulsivity scale is psychometrically reliable and valid for use with IDSOs.

7.10.3 The Adapted Ruminations Scale

The Cronbach Alpha coefficient was .78 ($N = 128$) pre treatment and .79 ($N = 129$) post treatment. The 11-item measure had adequate internal consistency at both the pre and post treatment stages. Removing one item (item 15) improved the internal consistency to 0.79 pre treatment and 0.8 post treatment.

Principal components analysis revealed the presence of two components with eigenvalues exceeding 1, explaining 46.6% of the variance in the data. Component 1 accounted for 35.6% of the variance alone. Inspection of the screeplot revealed a clear break after the first component. Using Cattell's (1966) scree test, it was determined that the adapted ruminations scale is comprised of one component. On closer inspection of the component matrix, all questions loaded strongly ($>.4$) on component 1 except for item 14, which loads most strongly on the second component. Item 14 was not clinically different from the other items and so it was retained within the component. Item 15 did not load onto either component. Given the results from the internal consistency analysis, a decision was made to remove item 15 from the scale. All subsequent analysis is based on a 10 item scale. The factor loadings for each question are reported in Table 7.5.

Table 7.5:

Factor loadings for all items on the adapted ruminations scale.

Item	Component 1	Component 2
Q4: Does it take you years to get rid of a grudge?	.790	
Q7: Do you hold grudges for a long time?	.782	
Q3: Do you forgive easily?*	.727	
Q11: If someone harms you, are you not able to relax until you have got your own back?	.637	
Q12: When something angers you, does thinking about it make you even more angry?	.579	.339
Q6: Do you feel so strongly about some of the things that have been done to you that you won't accept any excuses?	.529	
Q5: Do you always get your own back if someone wrongs you?	.498	-.391
Q10: Do you still remember the wrongs that have been	.466	

done to you even after many years?		
Question 2: Do you prefer to have to wait to get your own back?	.443	-.348
Question 14: Do you find it difficult to sleep because you can't stop thinking about a wrong that has been done to you?	.338	.749

*denotes items that are reverse scored

The adapted ruminations scale is psychometrically reliable and valid for use with IDSOs.

7.10.4 The Adapted Relationship Style Questionnaire

The Cronbach Alpha coefficient for the adapted relationship style questionnaire was .85 ($N = 127$) pre treatment and .81 ($N = 130$) post treatment. The 30-item measure had good internal consistency at both the pre and post treatment stages.

Principal components analysis revealed the presence of nine factors with eigenvalues exceeding 1, explaining 64.65% of the variance in the data. Inspection of the screeplot revealed a clear break after the fourth component. Using Cattell's (1966) scree test, it was determined that the adapted relationships scale is comprised of four components.

To aid in the interpretation of these 4 components, Varimax rotation was undertaken. The rotated solution revealed the presence of 4 factors which explained 43.305% of the total variance. Component 1 contributed 17.20%, Component 2 contributed 11.32%, component 3 contributed 7.98% and component 4 contributed 6.81% of the variance. Items which loaded on more than one component were examined and assigned to one of the components based on the strength of their loading and their conceptual link with the other items in the factor. Those that loaded uniquely and highly onto a factor were retained ($>.4$). There was one item which did not load onto any of the components (item 6) and 4 items which had a low loading ($<.4$) which were removed from the scale (items 12, 15, 10, 29). Where an item loaded strongly ($>.4$) on more than one item, a decision was made based on the strength of the loading. As such, item 13 was included in component 1.

The internal consistency of the newly formed components was analysed. The Cronbach's Alpha coefficient for component 1 was .87 ($N = 130$) pre treatment and .83 ($N = 130$) post treatment. This component demonstrates good internal consistency at both stages. The Cronbach's Alpha Coefficient for component 2 was .73 ($N = 130$) pre treatment and .71 ($N = 131$) post treatment. This component demonstrated adequate internal consistency at both stages. The Cronbach's Alpha coefficient for component 3 was .67 ($N = 131$) pre treatment and .87 ($N = 131$) post treatment. This component demonstrated borderline/ adequate consistency pre treatment and good internal consistency post treatment despite the fact that there are only 3 items in the subscale. The Cronbach's Alpha coefficient for component 4 was .47 ($N = 130$) pre treatment and .46 ($N = 131$) post treatment. This component has poor internal consistency at both pre and post treatment stages and as such this component was dropped from any further analysis.

The adapted relationships style assessment measure can best be described by a three factor solution comprised of the following components; "fearful of relationships," "depending on others" and "wanting a relationship." These three components contribute to 37.11% of the variance. "Fearful of relationships" contributes to 17.77% of the variance, "depending on others" contributes to 11.22% of the variance, and "wanting a relationship" contributes to 8.12% of the variance. The factor loadings are reported in Table 7.6.

Table 7.6:

Factor loadings for all items on the adapted relationships style questionnaire (rotated component matrix).

Item	Fearful of relationships	Depending on others	Wanting a relationship
Q20: Do you get nervous when someone gets too close to you?	.720		
Q21: Do you worry that romantic partners will not want to stay with you?	.713		
Q5: Do you worry that you will get hurt if you get too close to others?	.694		
Q28: Do you worry that others will not like you?	.667		.315
Q11: Do you worry that romantic partners do not really love you?	.612		
Q16: Do you worry that others don't think as much of you as	.597		

you think of them?			
Q18: Are people sometimes scared away by how close you want to be to them	.587		
Q13: Do you worry about having people too close to you?	.548	.421	
Q23: Do you worry about being left on your own?	.545		.441
Q9: Do you worry about being alone?	.543		.492
Q25: Do you find that others do not want to get as close as you would like?	.534		
Q24: Do you feel uncomfortable when you are close to someone else?	.505		
Q30: Do you find it easy to get close to other people*	.408	.324	
Q27: Are other people there when you need them?*		.755	
Q7: Can you always depend on others to be there when you need them?*		.713	
Q17: Are people there when you need them?*		.705	
Q26: Do you prefer it when you do not depend on others?		.533	
Q10: Do you feel ok about depending on other people?*		.411	
Q8: Do you want to be emotionally close to another person?			.735
Q14: Do you want to be in emotionally close relationships?			.717
Q4: Do you want to feel completely connected with a partner?			.616

*denotes items that are reverse scored

The adapted relationships scale and its three components are psychometrically reliable and valid for use with IDSOs.

7.10.5 The Adapted Openness to Women Scale

The Cronbach Alpha coefficient was .75 (N = 129) pre treatment and .69 (N = 131) post treatment. The 9-item measure has adequate internal consistency at both the pre and post treatment stages. Removing one item (item 9) improved the internal consistency to .75 pre treatment. Deleting items 8 and 9 improved internal consistency to .72 post treatment.

Principal components analysis revealed the presence of three factors with eigenvalues exceeding 1, explaining 62.18% of the variance in the data; component one accounted for 35.27% of the variance, component 2 accounted for 15.56% of the variance and component 3 accounted for 11.35% of the variance. Inspection of the screeplot revealed a clear break after the first and the third component. On closer inspection of the component matrix, it was clear that all items load strongly (>.4) on component 1 except for items 8 and 9 which load heaviest on component 2. Given

the results from the internal consistency analysis, a decision was made to remove items 8 and 9 from the scale. All subsequent analysis is based on a 7 item scale. The factor loading for each question on this single factor is reported in table 7.7

Table 7.7:

Factor loadings for all items on the adapted openness to women scale.

Item	Component 1
Q2: Women usually like me	.751
Q5: I find it hard to talk to women*	.726
Q4: Women find it easy to be friends with me	.695
Q3: I find it easy to make friends with women	.669
Q7: I can talk about my problems with women	.581
Q1: I like spending my time talking to women	.571
Q6: I am very shy with women*	.551

*denotes items that are reverse scored

The adapted openness to women scale is psychometrically reliable and valid for use with IDSOs.

7.10.6 The Adapted Openness to Men Scale

The Cronbach Alpha coefficient was .73 ($N = 128$) pre treatment and .68 ($N = 131$) post treatment. The 9-item measure has adequate internal consistency at both the pre and post treatment stages. Removing one item (item 8) improves the internal consistency to .76 pre treatment. Removing item 3 post treatment improves the internal consistency to .69.

Principal components analysis revealed the presence of three factors with eigenvalues exceeding 1, explaining 61.36% of the variance in the data; component 1 accounted for 34.03% of the variance, component 2 accounted for 15.99% of the variance and component 3 accounted for 11.35% of the variance. Inspection of the screeplot revealed a clear break after the first and then the third component. On closer inspection of the component matrix, it was clear that all items loaded strongly ($>.4$) on component 1 except for items 8 and 3 which load heaviest on component 2. Given the results from the internal consistency analysis, a decision was made to remove items 8

and 3 from the scale. All subsequent analysis is based on a 7 item scale. The factor loading for each question on this single factor is reported in table 7.8.

Table 7.8:

Factor loadings for all items on the adapted openness to men scale.

Item	Component 1
Q6: I am very shy with other men*	.783
Q5: I find it hard to talk to men*	.734
Q2: I like spending my time talking to men	.642
Q1: I find it easy to make friends with men	.636
Q9: Men find it easy to be friends with me	.598
Q4: I can talk about my problems with men	.533
Q7: Men usually like me	.522

*denotes items that are reverse scored

The adapted openness to men scale is psychometrically reliable and valid for use with IDSOs.

7.10.7 The Sex offender Opinions Test

The internal consistency of the SOOT was tested. The Cronbach Alpha coefficient was .83 ($N = 124$) pre treatment and .86 ($N = 129$) post treatment demonstrating that the SOOT had good internal consistency at both treatment stages. The removal of item 9 improved internal consistency to .84 pre treatment and .87 post treatment. Removal of item 18 improved internal consistency to .83 pre treatment and .86 post treatment. Previous research (Williams et al., 2007) determined that the SOOT was comprised of 2 subscales. The internal consistency of these 2 subscales was tested within this data set. The Cronbach Alpha coefficient for the “deceitful women and children” subscale was .82 ($N = 126$) pre treatment and .85 ($N = 129$) post treatment. This subscale had good internal consistency at both stages. The Cronbach Alpha coefficient for the “children sex and the law” subscale was .71 ($N = 128$) pre treatment and .76 ($N = 131$) post treatment. This subscale has adequate internal consistency at the pre and post stages. Removing one item (item 19) improved the internal consistency to .77 post treatment.

Principal components analysis revealed the presence of six components with eigenvalues exceeding 1, explaining 60.7% of the variance in the data. The proportion of the variance accounted for by each component with an eigenvalue >1 was component 1 (25.58%), component 2 (10.65%), component 3 (7.95%), component 4 (6.2%), component 5 (5.28%), component 6 (5.08%). Inspection of the screeplot revealed a clear break after the fourth component. However closer inspection revealed that the third and fourth components had very few items with strong loadings. As such, a three component solution was retained. The separation into two components (deceitful women and children and children sex and the law) as suggested by previous research (Williams *et al.*, 2007) is not supported by the analysis.

To aid the interpretation of these three components, Varimax rotation was performed. All three components show a number of strong loadings. The three factor solution explained a total of 44.19% of the variance, with component 1 contributing 16.85% of the variance, component 2 contributing 13.75% of the variance and component 3 contributing 13.59% of the variance. Items that loaded on more than one component were examined and assigned to a component based on the strength of their loading and their conceptual link with other items in that component. Those that loaded uniquely and highly (>.4) onto a component were retained. There were two items that had a low loading and were removed from the scale; Item 9 (When women are raped they hate men), and 17 (Having sex with a male child is worse than having sex with a female child). Where an item loaded strongly (>.4) on more than one item, a decision was made based on the strength of the loading. As such, items 10 and 2 were assigned to component 3.

The first component was comprised of 8 items and was titled “women and children can not be trusted.” The Cronbach’s Alpha coefficient for this component was .78 ($N = 129$) pre treatment and .91 ($N = 131$) post treatment demonstrating good internal consistency at both stages. The second component (5 items) described “child abuse supportive beliefs.” The Cronbach’s Alpha coefficient for this component was .71 ($N = 128$) pre treatment and .76 ($N = 131$) post treatment

demonstrating adequate internal consistency at the pre and post stages. Lastly, “beliefs that men should dominate women” were clustered within the third component (5 items). The Cronbach’s Alpha coefficient was .7 ($N = 128$) pre treatment and .7 ($N = 131$) post treatment demonstrating adequate internal consistency at both stages. The factor loadings are reported in Table 7.9

Table 7.9:

Factor loadings for all items on the sex offender opinions test (rotated component matrix).

Item	Women and children can not be trusted	Child abuse supportive beliefs	Beliefs that men should dominate women
Q5: Women tell lies about men	.773		
Q1: Many women pretend that they have been raped	.657		
Q11: Women like to get men into trouble	.634		
Q16: Children like to get grown ups into trouble	.598		
Q12: Children tell lies	.591		
Q20: Children lead grown ups on	.441		
Q4: When a woman says ‘no’ she does not always mean it	.432		
Q7: A woman likes a man to take charge during sex	.406		
Q15: Children like to try out sex with grown ups		.718	
Q14: Children enjoy having sex with grown ups		.718	
Q18: You can have sex with children to teach them		.693	
Q13: Having sex with children is just a way of showing love		.626	
Q19: The law should let children have sex		.612	
Q8: A woman should not refuse to have sex			.821
Q3: Only bad women get raped			.770
Q6: A man needs to show a woman who’s boss			.670
Q10: Women who wear short skirts are asking for trouble	.458		.475
Q2: A woman can always stop herself being raped	.432		.446

The SOOT and its 3 components are psychometrically reliable and valid for use with IDSOs.

7.10.8 The My Private Interests Measure

The Cronbach Alpha coefficient for the MPI measure was .88 ($N = 48$) pre treatment and .88 ($N = 100$) post treatment. The removal of items 24 and 47 post treatment improved the alpha to .89.

A principal components analysis (PCA) using SPSS was conducted on the MPI to determine the factor structure of the scale. An immediate problem with the data set was identified. Approximately 70% of the men had not completed 2 items of the measure. On closer inspection, it became obvious why there were so many missing scores. Questions 13 and 34 had been printed outside of the main body of the questionnaire and clearly administrators had overlooked these items during interview. Due to the extensive missing data, these 2 items were excluded from any further analysis. They were: Q 13 "At times it is hard to stop myself touching children" and Q 34 "Men who have lots of sex are happier than those who do not." Inspection of the data also revealed that some items had zero variance. None of the participants responded yes to certain items pre or post treatment. These items were not adding to the data and were removed from any further analysis. These items were: Q 22 "I would like to have sex with a dead body," Q 25 "I would like to have sex with an animal," Q 42 "I like being hurt during sex," Q 49 "I get turned on thinking about human excrement (poo)."

By default, Principal component analysis uses listwise deletion of cases with missing values, i.e. a case is omitted from the analysis if it is missing on any of the variables in the Factor variable list. With pairwise deletion, each correlation is computed from all cases that are nonmissing on those 2 respective variables, without regard to their 'missingness' on the other variables in the list. PCA was performed using listwise deletion of missing variables on the remaining items in the data set. It revealed the presence of 15 components with eigenvalues exceeding 1, explaining 78.08% of the variance in the data. Inspection of the screeplot revealed a clear break after the fourth component. On closer inspection of the component matrix, 4 components were confirmed.

To aid the interpretation of these four components, Varimax rotation was performed. The four factor solution explained a total of 39.84% of the variance, with component 1 contributing 19.26%, component 2 contributing 7.89% of the variance, component 3 contributing 6.63% of the variance and component 4 contributing 6.05% of the variance. Items that loaded on more than one factor were examined and assigned to the factor based on strength of their loading and their conceptual link with other items in that factor. Those that loaded uniquely and highly onto a factor ($>.4$) were retained. The first component was titled “problematic sexual interest in children” and was comprised of 12 items. The second component was titled “paraphillic sexual interests” and was comprised of 5 items. The third component was titled “sexual preoccupation” and was comprised of 8 items. The fourth component was titled “preference for sexualised violence” and was comprised of 5 items. The factor loadings are reported in Table 7.9.

Table 7.10:

Factor loadings for all items on the My Private Interests measure.

Item	Problematic sexual interests	Paraphillic sexual interests	Sexual preoccupation	Preference for sexualised violence
Q18: I start to feel turned on when I think about having sex with a child	.907			
Q8: I prefer sex when it is violent	.900			
Q1: I have sexy thoughts about children	.857			
Q17: I feel turned on thinking about when a child touches my penis	.785			
Q4: Sometimes it is hard to stop myself touching a child	.734			
Q52: My sexy thoughts are a problem to me	.670			
Q53: It turns me on when kids show interest in sex	.655			
Q3: I have sexy thoughts about boys	.621			
Q50: I like looking at pictures of naked children	.620			
Q16: I feel turned on thinking about a child giving me a blow job	.552			
Q44: My sexual interests have ruined my life	.473			
Q15: I have sexy thoughts about girls	.398			
Q46: I like tying people up when I am having sex		.920		
Q39: I like scaring partners when I am having sex so that they beg me to stop		.920		

Q14: I have sexy thoughts about kidnapping people so that I can have sex with them	.760		
Q27: Secretly I liked to dress in women's clothes	.635		
Q19: I like to use objects when I am having sex (like leather, whips, handcuffs)	.555		
Q38: I am always thinking about sex	.344	.696	
Q51: I can't stop thinking about sex	.408	.681	
Q41: Sex is on my mind all the time	.461	.597	
Q29: I like secretly watching others (peeping)		.584	
Q26: I get turn on (sexually excited) when someone is urinating (having a pee)	.365	.515	
Q20: I can't seem to get sex out of my mind	.440	.508	
Q6: I have a higher sex drive than other men		.492	.379
Q54: I like humiliating or putting my partner down when I am having sex	.372	.410	
Q7: I prefer sex when it is violent			.873
Q21: I like to hurt my partner when I am having sex			.873
Q11: I feel turned on when I think about hurting someone during sex			.784
Q23: I think that there is something wrong with my sex organs	.374		.543
Q32: I have thoughts about raping someone			.453

There were 17 items that had a low loading ($<.4$) which were removed from any subsequent analysis. These were; Q 10 "I like to be in control when I am having sex," Q 28 "I like pressing myself up against strangers," Q 2 "I am gay (homosexual)," Q 40 "I like parts of the body that others don't seem to find sexually exciting (like hair, feet)," Q 48 "I would like to be tied up and forced to have sex," Q 47 "Sometimes I have gone out specially to look for people to have sex with (like car parks)," Q 24 "Sometimes I can't get an erection when I am having sex," Q 5 "I feel better about myself when I am having lots of sex," Q 33 "I like looking at sex magazines/ books/ videos," Q 12 "I enjoy sex when my partner is also enjoying themselves," Q 43 "I like phoning up people and frightening them," Q 31 "I like forcing someone to have sex when they don't want to," Q 35 "I only have sex when I know my partner also wants sex," Q 36 "I have had thoughts about killing someone when I am having sex," Q 37 "I have an illness which affects me sexually," Q 30 "I like wearing certain things when I am having sex."

The internal consistency of each of the newly formed components was tested. The Cronbach Alpha coefficient for problematic sexual interests in children was .90 ($N = 130$) pre treatment and .89 ($N = 131$) post treatment demonstrating excellent internal consistency. The Cronbach Alpha coefficient for the paraphilic interests subscale was .80 ($N = 131$) pre treatment and .00 ($N = 131$) post treatment (the scale had zero variance post treatment) demonstrating good internal consistency at the pre treatment stage but very poor internal consistency post treatment. Closer inspection of the data set revealed that there was a very low endorsement of the items within this component across the data set. At the post treatment stage only one of the items, I like to use objects when I am having sex (like leather, whips, handcuffs), was endorsed (and only by 7 of the participants). As such, a decision was made not to undertake any further analyses on the “paraphilic interests” component. The Cronbach Alpha coefficient for the sexual preoccupation subscale was .87 ($N = 130$) pre treatment and .89 ($N = 131$) post treatment demonstrating good internal consistency at both stages. The Cronbach Alpha coefficient for the preference for sexualised violence subscale was .66 ($N = 131$) pre treatment and .32 ($N = 131$) post treatment demonstrating adequate internal consistency at the pre treatment stage but inadequate internal consistency at the post treatment stage. A decision was made to retain this component, despite the poor internal consistency post treatment. It is normal practice within the field to report pre treatment scores only (for further details on this see discussion).

7.11 Discussion

All of the assessment measures were found to have reasonable psychometric properties as determined by internal consistency and principal components analyses. The adapted self esteem questionnaire had good internal consistency at both the pre and post treatment stages. This result adds support to the findings of Williams *et al.*, (2007). The adapted impulsivity scale and the adapted ruminations scales reported good and adequate reliability at both pre and post treatment stages which could be improved through the deletion of one item (in both scales). With regard to

the adapted relationship style questionnaire, three reliable components were found through principle components analysis. The first component related to fearful of relationships, the second component related to depending on others. The final component related to wanting a relationship. The openness to women and openness to men scales both demonstrated adequate consistency at both pre and post treatment stages. The analysis of the SOOT suggested different results to those found by Williams *et al.*, (2007). Three reliable components were identified. The first component related to beliefs that women and children can not be trusted. The second component related to child abuse supportive beliefs. The final component related to beliefs that men should dominate women. Two items were removed from the scale.

The results of the My Private Interests measure are worthy of more in depth discussion. The internal consistency of the whole MPI measure was good at both the pre and post treatment stages, despite some problems with the way in which the assessment had been printed which meant that the majority of the participants had not completed 2 of the items. A four factor structure demonstrated reasonable internal consistency across all four components at the pre treatment stage, but this was not replicated post treatment. The first component, problematic sexual interests in children, had excellent pre treatment internal consistency and adequate post treatment reliability. The second component, paraphillic interests had good internal consistency pre treatment, but there was zero variance in the scores post treatment. In explaining these results, it is important to report on an examination of the dataset. The “paraphillic interests” component is comprised of the following items; “I like tying people up when I am having sex,” “I like scaring partners when I am having sex so that they beg me to stop,” “I have sexy thoughts about kidnapping people so that I can have sex with them,” “Secretly I like to dress up in women’s clothes,” and “I like to use objects when I am having sex (like leather, whips, handcuffs).” There was a very low endorsement of the items across the data set. At the post treatment stage only one of the items, “I like to use objects when I am having sex (like leather, whips, handcuffs),” was

endorsed (and only by 7 of the participants). Given the very low response rate on this component, a decision was made not to undertake any further analyses. It seems that the respondents in this sample report few paraphillic sexual interests, especially post treatment. Given that pre treatment, this component accounted for nearly 8% of the variance, it should be retained as a subscale of the MPI and subjected to further research. The third component, sexual preoccupation demonstrated good internal consistency at both treatment stages. The final component, preference for sexualised violence demonstrated adequate consistency pre treatment, but poor and inadequate reliability at the post treatment stages. Although the post treatment reliability was considered poor, a decision was made to retain this component in light of the standard practice reported in other studies. In two other studies which have been undertaken using the MPI, internal consistency has only been established pre treatment. Mathie (2008) in a study of 248 IDSOs found a four factor structure. Her study included all of the MPI variables. Pre treatment internal consistency results were reported as good to excellent. The four components were “sexual preference for children”, “obsessed with sex”, “preferring sex to include violence or humiliation”, and “other offence related sexual interests”. Given that this data set was also IDSOs, the researcher tried to replicate Mathie’s components with this data set, but the applicability of the four components identified by Mathie was not supported in this data set, yet the nature of the four components identified are similar to those identified in this study. In Mathie’s examination of pre to post ASOTP treatment change, improvements were found in the desired direction for the sexual preference for children and obsessed with sex subscales. The “preferring sex to include violence or humiliation” and the “other offence related sexual interests” subscales showed deterioration after treatment).

More recently, Farren and Barnett (in preparation) tested the MPI measure on 1,013 mainstream (non ID) adult males convicted of sexual offences in prison or on probation in England and Wales. Factor analysis specified four components, similar to those identified with IDSOs in this

study and Mathie's study. The components were known as "sexual preoccupation", "sexual preference for children", "sexualised violence" and "other offence related sexual interest". Pre treatment internal consistency was reported as good to excellent for all four components. It seems therefore that there is a consistent pattern across all of the studies reported, that a four factor solution provides the best solution. These four components are related to known criminogenic needs for offence related sexual interest.

Interestingly, both the Mathie and Farren and Barnett studies only calculated reliability results at the pre treatment stage. It is common practice within the field to determine the internal consistency of the measure at the pre treatment stage only. The results of this study therefore provide new information about the way in which the reliability of two components on this measure may change as a consequence of treatment. The internal consistency should not, in theory, be affected by whether someone has been exposed to treatment or not, but post-treatment scores may be affected by how people respond (i.e. in a socially desirable manner to appear 'more' treated) which may result in alterations to particular items, and how they 'fit' with the rest of the scale, which in turn may change the internal consistency. It seems that the post treatment results may have been affected by this.

It is important however, to note that the study is based on a relatively small sample, particularly in relation to the principal components analyses which were undertaken. Pallant (2004) notes that there is little agreement among authors about how large a sample should be when undertaking PCA/ factor analysis. In small samples the correlation coefficients among the variables are less reliable, tending to vary from sample to sample. Tabachnick and Fidell (1996) recommend at least 300 cases. Other researchers suggest that it is not the overall sample size that is the concern, rather the ratio of subjects to items. Nunnally (1978) recommends a 10 to 1 ratio. As such, if we are to follow Nunnally's advice, it is clear that for some of the larger assessment measures analysed in this study (notably the adapted relationship style questionnaire, the SOOT

and the MPI), a larger sample size would have been helpful. It is recommended that these analyses are repeated with larger samples. It would have also been advantageous to be able to collect test retest data to enhance the reliability of the assessments. Unfortunately, as has been reported earlier, due to the fact that the BNM assessments are resource intensive this was not possible for the present study.

7.12 Conclusions

In the existing literature, there were few reliable nor valid measures of relevant criminogenic needs for IDSOs. As such, this research set out to establish the psychometric properties of eight assessment measures which had been specifically adapted or developed for use with this client group.

The BNM assessment battery provides reliable and valid ways of measuring the criminogenic needs of IDSOs. This study therefore makes a contribution to the current literature base on the assessment of IDSOs which has been reported as sparse (Lindsay, 2002). It also provides support for the need to, and importance of, validating adapted versions of measures on different populations (Kroner and Weekes, 1996; Lindsay, 2002) and casts light on the testing of reliability and validity pre and post treatment.

Chapter 8: BNM Outcome evaluation

In order to evidence the effectiveness of any treatment approach, outcome data is needed to see if the treatment has been successful. In order to investigate the impact of the BNM treatment approach a pre post outcome study was designed.

8.1 Aim

The aim was to determine whether the participants make changes in the desired direction as a result of BNM treatment. It was hypothesised that participants on the BNM will achieve positive change on the outcome measures administered and that positive change (as appropriate) would be achieved irrespective of risk, IQ level, age, or offence type.

8.2 Method

8.3 Design

The sample utilised for the evaluation of the psychometric measures was also used in this study. Given that the majority of the measures and subscales were found to have adequate psychometric properties in study 1, they were used to examine change (except the paraphillic interests subscale within the MPI). Post testing was conducted in exactly the same way as pre testing, on a one to one individual basis approximately 6 weeks after treatment had completed. All psychometric testing was undertaken by specially trained staff at the treatment sites.

8.4 Non- completers of treatment

Men who started treatment but did not complete are described as “non completers” and are not represented in this sample, as they would not have completed the post-treatment assessments. Nine men started BNM but did not complete treatment. This represents an average non completion rate of 7% which is slightly lower than the non completion rate reported on the ASOTP

(predecessor of the BNM) which was 8.5% during 2008/09. A brief case description of the non completers with the reasons for their non completion is provided below.

Table 8.1:

Mr A Case summary

Age	Ethnicity	Sentence length	Risk	IQ	Total number of sessions attended
34	Pakistani	IPP	High	72	68

Mr A was sentenced to an Indeterminate Sentence for Public Protection for the offences of sexual assault on a female and unlawful wounding. Mr A had a history of mental illness, which at the time of assessment, was considered to be stable. However, during treatment he started to say that people were trying to ‘stitch him up.’ He was observed to be having conversations with himself, mumbling under his breath, displaying suspicious thinking about prisoners and staff, animated and erratic speech and body language, an inability to focus on session topics, going off on tangents when speaking and quickly switching emotions from angry/ frustrated to crying in the toilets. Advice was sought from the Mental Health In-Reach team. Mr A was located in the healthcare unit where he lost weight rapidly. He suggested this was because the cleaner had told him that the food was contaminated. In addition, Mr A was self-reporting problems on the wing to both facilitators and wing staff, including feeling put under pressure by other Muslims on the wing. He submitted allegations of bullying from his “Muslim brothers” who were putting pressure on him not to come to the group because they claimed it went against the religion.⁴ Mr A was finally removed from BNM and was relocated to the Segregation unit.

⁴ HM Prison Service has a national strategy to reducing violence in prisons that is responsive to local needs. This is outlined in Prison Service Instruction 64/2011

Table 8.2:

Mr B Case summary

Age	Ethnicity	Sentence length	Risk	IQ	Total number of sessions attended
44	White British	IPP	Very High	71	1

Mr B was sentenced to an Indeterminate Public Protection for an offence of kidnap which was committed against two adult females who were unknown to him. Despite initially claiming a strong motivation to attend treatment, during the first session Mr B claimed that he was not a sexual offender and as such he should not be attending BNM. He demanded to go back to the wing and left treatment.

Table 8.3:

Mr C Case summary

Age	Ethnicity	Sentence length	Risk	IQ	Total number of sessions attended
26	Black	84 months	High	69	8

Mr C was convicted for three offences of rape and two offences of sexual assault against a 15 year old and a 12 year old girl. Mr C missed 4 sessions during the first 3 weeks of treatment. During his time in treatment it was unclear as to how keen Mr C was about changing his behaviour. He stated that he “couldn’t be arsed.” He would sigh and slump in his chair throughout the sessions which raised a question about his motivation. He also said that he did not understand everything that was being said in the group and was offered support outside the sessions. He continued to fail to attend treatment on a regular basis which resulted in deselection.

Table 8.4:

Mr D Case summary

Age	Ethnicity	Sentence length	Risk	IQ	Total number of sessions attended
26	White British	46 months	Very High	74	Exit at block 7

Mr D has a history of sexually inappropriate behaviour and has previously received a residential order for indecent assault. This conviction is for the rape of a vulnerable female adult. Mr. D's motivation to attend fluctuated with occasions of disruptive and disrespectful behaviour in group. When the focus of the group was on him during his account of his offence his behaviour deteriorated. Concerns were raised in relation to fears that he may wish to harm himself following two incidents. Firstly, the misuse of medication namely sleeping tablets and second during group, Mr D stated that he was going to kill himself. Mr D removed himself from BNM stating that this was not the right time for him to be on a course, as he needed to "sort his head out first."⁵

Table 8.5:

Mr E Case summary

Age	Ethnicity	Sentence length	Risk	IQ	Total number of sessions attended
36	White British	45 months	High	67	12

Mr E is convicted of having sexual activity with a child and abuse of trust. Mr E had a continual problem during the course with another group member. This culminated in a heated discussion

⁵ In line with Prison Service Instruction 64/2011, Mr D's needs were managed under the Assessment, Care in Custody and Teamwork ('ACCT') framework. ACCT is a prisoner-centred flexible care-planning system which is designed to reduce the risk of suicide and self-harm.

where Mr E was abusive and disrespectful. Mr E said that he could not work in a group setting with this group member and so left treatment.

Table 8.6:

Mr F Case summary

Age	Ethnicity	Sentence length	Risk	IQ	Total number of sessions attended
38	White British	48 months	Medium	58	35

Mr F was convicted of false imprisonment of one female victim and the sexual assault of another. Mr F was found to be discussing the names and details of offences of members of the group with another prisoner and was removed from treatment.

Table 8.7:

Mr G Case summary

Age	Ethnicity	Sentence length	Risk	IQ	Total number of sessions attended
46	White British	108 months	High	71	1

Mr G is convicted of sexual assault and rape of his daughter from age 12 to 15. Mr G was removed from treatment following a breach of confidentiality where he was found to be gossiping about other people's offences on the wing.

Table 8.8:

Mr H Case summary

Age	Ethnicity	Sentence length	Risk	IQ	Total number of sessions attended
51	White British	10 years	Very High	80	26

Mr H was sentenced to 10 years imprisonment for Cruelty to a person under 16 years x 4, Indecent assault x 2, Assault Occasioning Actual Bodily Harm (AOABH) x 11 and Causing Grievous Bodily Harm (GBH) with intent x 1. The index offences were perpetrated against four victims aged between 7 and 19 years and the abuse was perpetrated over a 19 year period. The main reason for removing Mr H from treatment was the threat of serious harm he posed to facilitators, group members and other prisoners. He reported offence related sexual and violent thoughts which were interfering with treatment (e.g. disclosures about wanting to kill others and fantasies about strangling a female facilitator).

Table 8.9:

Mr I Case summary

Age	Ethnicity	Sentence length	Risk	IQ	Total number of sessions attended
41	White British	36 months	Medium	63	7

Mr I was serving a 3yr custodial sentence for Breach of a Sexual Offences Prevention Order (SOPO). Mr I's motivation to stay in treatment fluctuated. He decided to leave treatment as he was soon to be released and felt his time would be better spent trying to secure a job. He felt that the restrictions placed on him through the SOPO were unfair and did not recognise that anything about his offending behaviour that gave concern.

8.5 Summary of the results from the non completers

The non-completers ranged in age from 26 – 51, with an average age of 38 ($SD = 8.56$). This is slightly higher than the average age of those completing treatment (mean age = 35.21). In terms of risk classification, 22% ($N = 2$) of the non completers were medium risk, 44% ($N = 4$) were high risk and 33% ($N = 3$) were very high risk. In comparison, in the completer group, 35% were medium risk, 43% were high risk and 21% very high risk. Small numbers of non completers make comparison difficult. The IQ scores of the non completers ranged from 63 to 80, with a mean IQ of 69.4. This is slightly lower than the IQ range of the sample who completed BNM treatment (mean

IQ = 71.5). Seven of the nine men described themselves as white British, 1 non completer was black and one Asian. These figures are in line with the completer sample.

The manner in which men left treatment was classified either as “voluntary” or as “removed” by the local treatment team. A group member, who despite efforts from the treatment team, decided that he wanted to leave treatment, would be classified as voluntarily leaving treatment. Where the decision to leave treatment was made by the treatment team, this was described as being “removed” from treatment. Five of the nine men were described as voluntarily leaving treatment. This means that the decision to leave was made by the individual, rather than by the treatment team. Of the nine non completers, two were removed for gossiping/ breaking confidentiality, one for actual violence against a fellow prisoner, and one for threatening violence to other participants and a therapist. Of the five who voluntarily left the programme, motivation to change appeared to be an issue. One claimed that he was not a sex offender, another said that this was not the right time for him, and the third said that he “couldn’t be arsed.” One group member left because he felt that given he was to be released within months he would rather get a job than attend treatment. The final group member decided to leave treatment due to problems with another group member.

Five of the nine men completed less than 15 sessions. It seems that participants who did not complete treatment, either volunteered or were removed from treatment before they completed their offence disclosure (which occurs at around this time in treatment). Three men did complete some offence disclosure work, but dropped out during this block. Only one participant completed all the disclosure work, but this group member had mental health concerns which meant that his attendance in treatment was disrupted.

Seventy seven per cent ($N = 7$) of the non completers were on fixed sentences. This finding is in contrast to the sample who completed treatment, where 64.1% ($N = 84$) were serving

indeterminate sentences (IPPS, Life Sentences). As has been mentioned previously, successful completion of an offending behaviour treatment approach like BNM, is often considered as evidence of addressing risk, and is therefore, helpful in contributing towards decision making in relation to progressive moves through the prison system and eventual release. This is an important factor for men on indeterminate sentences who seek to evidence how they have changed in order to qualify for progressive moves/ favourable consideration by the Parole Board. Men on fixed sentences do not have the same pressures to evidence any reduction in risk. Their release is not subject to the same levels of scrutiny as their indeterminate sentenced counterparts. They will be released whether or not they have completed any treatment for their sexually offending behaviour. This is a striking difference between completers and non completers. Further, 4 of the 9 non completers had relatively short sentences, less than 4 years. Once again this is in contrast to the sample who completed treatment, where 81% had a sentence length of over 4 years.

Poor mental health, (including suicidal thoughts), was reported for 3 of the non completers. The needs of this client group extend beyond their offence specific needs and as such can not be met by BNM. Given that all three men were assessed as mentally stable prior to treatment starting, it is of concern that during the course of treatment, their mental health destabilised to such an extent that an exit from treatment was required.

This research reports data from the 131 men who completed treatment only.

8.6 Analysis

The ability to detect change was tested using a series of one between (either age, IQ, risk or offence type) and one within (time) factor analysis of variance (ANOVA) to test for differences between two or more independent groups while subjecting participants to repeated measures. Although a MANOVA design incorporating a four between and one within variable was considered, this approach was ruled out because there was not enough statistical power due to the small

sample size. As Tabachnick and Fidell (1996) point out, when using MANOVA it is important to have more cases than dependent variables in every cell. As such, separate ANOVAs were carried out for each of the measures, and between-subjects factors.

Using the ANOVA model, one categorical independent variable is a *between-subjects* variable and the other categorical independent variable is a *within-subjects* variable. The between subjects variables of interest in this study were risk classification, IQ level, age or offence type (whether the offender had offended against an adult or a child). The within subjects variable was time (pre and post scores on the assessment measure).

Risk classification: The sample was divided in terms of risk classification (RM2000/ s) to examine whether there were any differences in effectiveness of treatment between the different risk categories of men who attended BNM. Three groups were created (Medium, High, and Very high). Table 8.1 shows the numbers of men in each category.

Table 8.10:

RM 2000 risk level (N = 131)

Risk level	Frequency	%
Medium	46	35.1
High	57	43.5
Very high	28	21.4

It was hypothesised that all treatment participants would show change in the desired direction on each of the assessment measures irrespective of their risk classification.

Level of intellectual functioning (IQ): The sample was divided in terms of IQ classification to examine whether any differences in treatment effectiveness between men as a result of IQ scores. The sample was divided into 2 approximately equal IQ bands; Lower IQ (IQ scores 58 – 71) and

Higher IQ (IQ scores 72 -83). In this way comparisons were made between the lower and higher IQ groups and treatment change.

Table 8.11:

IQ level (N = 131)

IQ level	Frequency	%
Lower band	56	42.7
Higher band	71	54.2
Missing information	4	3.1

It was hypothesised that all treatment participants would show change in the desired direction on each of the assessment measures irrespective of their IQ level.

Age: The sample ranged in age from 19 to 76 ($M = 35.21$, $SD = 12.81$). Three approximately equal age bands were created to help determine whether scores on the measures differed in terms of age of the participant. The three age bands were; young (age 19 – 26), middle aged (ages 27 – 40) and older (ages 41 -76).

Table 8.12:

Age (N = 131)

Age	Frequency	%
Young	44	33.6
Middle aged	42	32.1
Older	45	34.4

It was hypothesised that all treatment participants would show change in the desired direction on each of the assessment measures irrespective of their age.

Offence type: To determine whether scores on the measures differ in relation to whether the offender has a conviction against an adult (over age 17) or a child (16 and under), the relationship between child or adult offender and scores on each of the measures/ subscales were examined. The frequency of each offender type is shown in Table 8.4. There were 12 men who had committed “cross over offences” (those who have offended against both adults and children), these cases were closely examined and a decision based on the evidence available was made to determine their suitability for the adult or child offender group. Eight of the men in the cross over group had offences against teenagers and adults. A decision was made to add these men to the adult offender group. The remaining four men had offended against adult victims, but the majority of their offending (or their most serious offences) were committed against children, and as such, these men were incorporated within the child offender group.

Table 8.13:

Offence type (N = 131)

Offence type	Frequency	%
Child offender	68	51.9
Adult offender	46	35.1
Missing information	17	13

It was hypothesised that all treatment participants show change (as appropriate) in the desired direction on each of the assessment measures irrespective of whether they have offended against an adult or a child.

8.7 Relationships between the variables.

In order to determine if there were any statistically significant relationships between the variables (risk, IQ, age and offence type), a series of Chi square tests were undertaken.

Table 8.14:

Relationship between risk, IQ, age and offence type.

	χ^2	<i>df</i>	<i>p</i>
Age and risk	2.01	4	ns
Age and IQ	5.25	2	ns
Age and offence type	11.01	2	.004
Risk and IQ	.61	2	ns
Risk and offence type	2.46	2	ns
IQ and offence type	.32	1	ns

In summary, it seems that there are few relationships between the variables of interest. The only significant result relates to the age of the offender and the type of offence committed. More young offenders are convicted of offences against adults, whereas middle aged and older offenders have more convictions for offences against children.

It is difficult to know if this sample is representative of this group of offenders or not. There are few comparison groups available. The closest comparison group would be the sample used in the Williams *et al.*, (2007) study and it is clear that there are some similarities. The sample were IDSOs in custody. In the Williams *et al.*, study, the average IQ was 71.9 with a range from 56 – 80. In this study, a similar average result is reported, 71.5, with a range from 59 to 83. The majority of the sample were convicted of offences against children in both samples. However, in the Williams *et al.*, study, lower risk men were included in the sample. They constituted 18% of the sample population and as such, this sample represents a higher risk group. The other main difference between the samples appears to relate to age. The sample in this study is younger than previously reported. The average age is 35.2 years which contrasts to a mean age of 40.3 years in the Williams *et al.*, study. One third of the present study sample population is comprised of young men (under age 26). Given that age is an important variable in the risk algorithm, it is no surprise, given the

lower age of this sample, that they constitute a higher risk group than the sample in the Williams *et al.*, study.

8.8 Results

8.8.1 The Selfesteem questionnaire: Analysis of treatment change

A series of ANOVAs were conducted to explore the relationships between risk, IQ, age of the offender and offence type and pre and post treatment scores on the adapted self esteem questionnaire. Four mixed between subjects ANOVAs were conducted with pre and post treatment scores as the within subjects variable, and risk/ IQ/ age/ offence type as the between subjects variable. In these analyses, three effects were tested; the effects due to the between subjects variable, the effects due to the within subjects variable, and the interaction between the two factors.

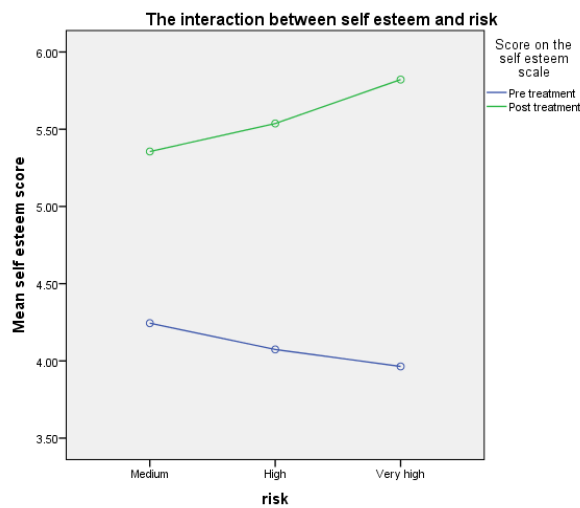
Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the self esteem questionnaire $F(2, 124) = .02, p > .05$. Thus, there was no significant difference in the scores of the medium risk group ($M = 4.80$) compared to the high risk group ($M = 4.81$) and the very high risk group ($M = 4.89$). A significant effect for the self esteem questionnaire scores pre and post treatment was obtained $F(1,124) = 49.66, p < .05$ as expected.⁶ Scores post treatment ($M = 5.54$) were significantly higher

⁶ In this research, multiple comparisons have been completed and, as such, it could be argued that this increases the probability of obtaining a statistically significant result when it is not warranted. To control for this, a Bonferroni adjustment can be applied which involves setting a more stringent alpha level for each comparison. It was decided that this was not necessary for a number of reasons. Firstly, the differences shown are significantly large that corrections, if applied, would not have an impact on the general trends. Secondly, as Gelman, Hill and Yajima (2012) illustrated, Bonferroni correction targets Type 1 errors at the expense of Type 2 errors. More simply put, although the correction reduces the number of false rejections, it increases the number of instances that the null is not rejected when in fact it should have been. Thus, the Bonferroni correction can severely reduce power to detect an important effect. Further, it is important to consider the wider context of this research. The research aimed to detect general patterns in the data. The efficacy of the results are considered in relation to the BNM treatment approach, a treatment programme which will be evaluated in different ways a number of times. As such, this research does not aim to, and will not make claims where a Type 1 error will have a major negative or life threatening impact or affect.

than those pre treatment ($M = 4.11$) indicating change in the desired direction. The interaction pre and post treatment scores X risk was not significant $F(2,124) = .94, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the self esteem questionnaire pre to post treatment in the medium risk group ($M = 4.24$ to $M = 5.36$), high risk group ($M = 4.07$ to $M = 5.54$) and very high risk group ($M = 3.96$ to $M = 5.82$), the interaction between risk and scores was not significant. The interpretation of the interaction is illustrated in figure 8.1.

Figure 8.1:

The interaction between self esteem and risk

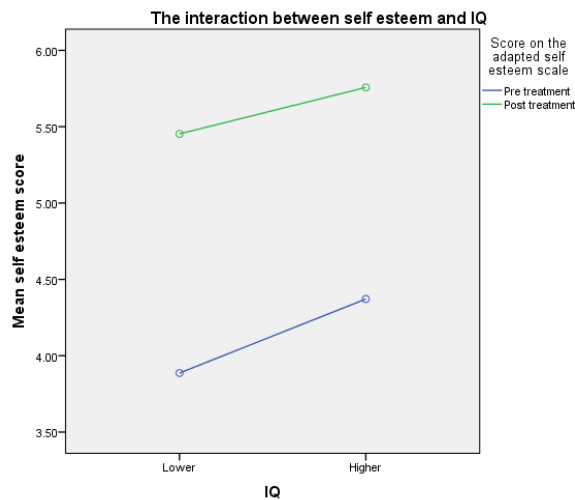


This profile plot illustrates the trend for an increase in mean scores on the self esteem questionnaire across medium, high and very high categories from pre treatment to post treatment. The trend suggests that the very high risk group improve the most over time in comparison to the high and medium risk groups. The analysis supports the hypothesis that treatment participants show change in the desired direction on self esteem scores irrespective of their risk classification.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the self esteem questionnaire $F(1, 121) = 1.16, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 4.67$) compared to the higher IQ group ($M = 5.06$). A significant effect for self esteem scores pre and post treatment was obtained $F(1, 121) = 49.56, p < .01$ as expected. Scores post treatment ($M = 5.63$) were significantly higher than those pre treatment ($M = 4.16$) indicating change in the desired direction. The interaction pre and post treatment scores X IQ was not significant $F(1, 121) = .19, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the self esteem questionnaire pre to post treatment in the lower IQ group ($M = 3.89$ to $M = 5.45$) and the higher IQ group ($M = 4.37$ to $M = 5.76$), the interaction between IQ and scores was not significant. The interpretation of the interaction is illustrated in figure 8.2.

Figure 8.2:

The interaction between self esteem and IQ



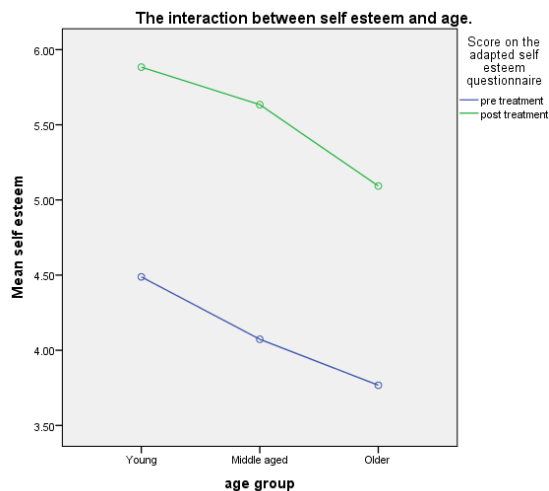
This profile plot illustrates the trend for an increase in mean scores on the self esteem questionnaire across the lower IQ and higher IQ groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The higher IQ group have higher self esteem scores than the lower IQ group at both the pre and post treatment stages. The analysis supports the

hypothesis that treatment participants show change in the desired direction on self esteem scores irrespective of their IQ classification.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the self esteem questionnaire $F(2,124) = 1.45, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 5.186$) compared to the middle age group ($M = 4.85$) and the Older age group ($M = 4.43$). As expected, a significant effect for self esteem scores pre and post treatment was obtained $F(1,124) = 49.35, p < .01$. Scores post treatment ($M = 5.54$) were significantly higher than those pre treatment ($M = 4.11$) indicating change in the desired direction. The interaction pre and post treatment scores X age was not significant $F(2,124) = .12, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the self esteem questionnaire pre to post treatment in the young age group ($M = 4.49$ to $M = 5.88$), middle age group ($M = 4.07$ to $M = 5.63$) and Older age group ($M = 3.77$ to $M = 5.09$), the interaction between age and scores was not significant. The interpretation of the interaction is illustrated in figure 8.3.

Figure 8.3:

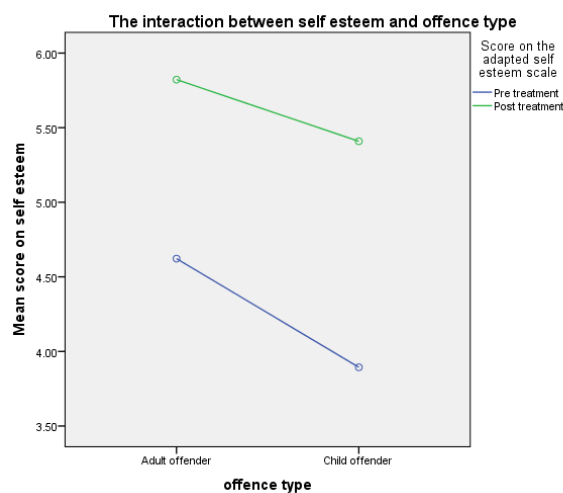
The interaction between self esteem and age



This profile plot illustrates the trend for an increase in mean scores on the self esteem questionnaire across young, middle and older age groups from pre treatment to post treatment. There is no interaction. Self esteem scores appear to decrease with age. The analysis supports the hypothesis that treatment participants show change in the desired direction on self esteem scores irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the self esteem questionnaire $F(1, 109) = .199, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = 4.65$) compared to the adult offenders ($M = 5.22$). As expected scores post treatment ($M = 5.58$) were significantly higher than those pre treatment ($M = 4.19$) indicating change in the desired direction. The interaction pre and post treatment scores X offence type was not significant $F(1,109) = .51, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the self esteem questionnaire pre to post treatment in the child offender group ($M = 3.89$ to $M = 5.41$) and in the adult offender group ($M = 4.62$ to $M = 5.82$), the interaction between offence type and self esteem scores was not significant. The interpretation of the interaction is illustrated in figure 8.4.

Figure 8.4: *The interaction between self esteem and offence type*



This profile plot illustrates the trend for an increase in mean scores on the self esteem questionnaire across both the adult offenders and child offenders groups from pre treatment to post treatment. The trend is parallel, there is no interaction. Adult offenders have higher self esteem at both the pre and post treatment stages than those who have offended against a child. The analysis supports the hypothesis that treatment participants show change in the desired direction on self esteem scores irrespective of whether they have offended against a child or an adult.

8.8.2 The Adapted impulsivity scale: Analysis of treatment change

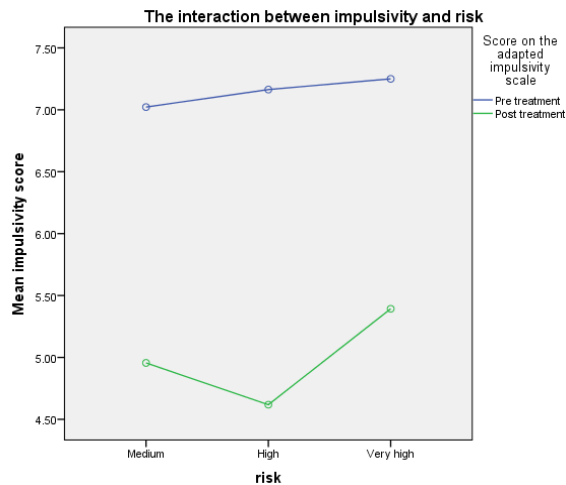
A series of ANOVAs were conducted to explore the relationships between risk, IQ, age of the offender and offence type and pre and post treatment scores on the adapted impulsivity scale. Four mixed between subjects ANOVAs were conducted with pre and post treatment scores as the within subjects variable, and risk/ IQ/ age/ offence type as the between subjects variable. In these analysis, three effects were tested; the effects due to the between subjects variable, the effects due to the within subjects variable, and the interaction between the two factors.

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the impulsivity scale $F(2, 125) = .24, p > .05$. Thus, there was no significant difference in the scores of the medium risk group ($M = 5.99$) compared to the high risk group ($M = 5.89$) and the very high risk group ($M = 6.32$). A significant effect for the impulsivity scale scores pre and post treatment was obtained $F(1, 125) = 39.41, p < .01$. As expected, scores post treatment ($M = 4.91$) were significantly lower than those pre treatment ($M = 7.13$) indicating change in the desired direction. The interaction pre and post treatment scores X risk was not significant $F(2, 125) = .38, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the impulsivity scale pre to post treatment in the medium risk group ($M = 7.02$ to $M = 4.96$), high risk group ($M = 7.16$ to $M = 4.62$)

and very high risk group ($M = 7.25$ to $M = 5.39$), the interaction between risk and scores was not significant. The interpretation of the interaction is illustrated in figure 8.5.

Figure 8.5:

The interaction between impulsivity and risk



This profile plot illustrates the trend for a decrease in mean scores on the impulsivity scale across medium, high and very high categories from pre treatment to post treatment. Pre treatment the scores for all of the risk groups were similar. Post treatment the high risk group appear to have made the most change, but this was not significantly more than the other risk groups. The analysis supports the hypothesis that treatment participants show change in the desired direction on the adapted impulsivity scale irrespective of their risk classification.

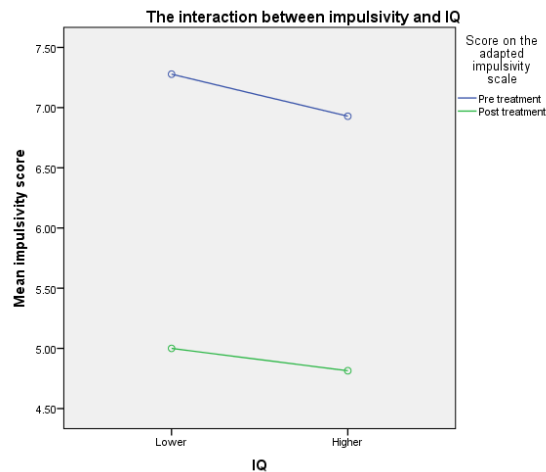
IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the impulsivity scale $F(1, 122) = .26, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 6.12$) compared to the higher IQ group ($M = 5.87$). A significant effect for impulsivity scores pre and post treatment was obtained $F(1, 122) = 42.76, p < .01$. Scores post treatment ($M = 4.90$) were significantly lower than those pre treatment ($M = 7.08$) indicating change in the desired direction which was expected. The

interaction pre and post treatment scores X IQ was not significant $F(1,122) = .06, p > .05$.

Examination of the cell means indicated that although there was a decrease in scores on the impulsivity scale pre to post treatment in the lower IQ group ($M = 7.28$ to $M = 5.00$) and the higher IQ group ($M = 6.93$ to $M = 4.81$), the interaction between IQ and scores was not significant. The interpretation of the interaction is illustrated in figure 8.6.

Figure 8.6:

The interaction between impulsivity and IQ



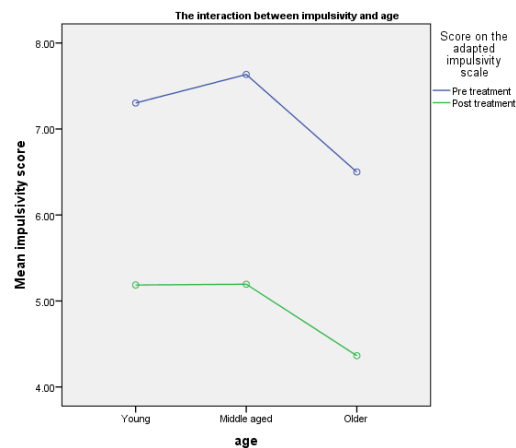
This profile plot illustrates the trend for a decrease in mean scores on the impulsivity scale across the lower IQ and higher IQ groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the adapted impulsivity scale irrespective of their IQ classification.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the impulsivity scale $F(2,125) = 1.63, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 6.24$) compared to the middle age group ($M = 6.42$) and the Older age group ($M = 5.43$). A significant effect for impulsivity scores pre and post treatment was obtained $F(1,125) = 45.41, p < .01$. As expected,

scores post treatment ($M = 4.91$) were significantly lower than those pre treatment ($M = 7.13$) indicating change in the desired direction. The interaction pre and post treatment scores X age was not significant $F(2,125) = .1, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the impulsivity scale pre to post treatment in the young age group ($M = 7.30$ to $M = 5.2$), middle age group ($M = 7.63$ to $M = 5.2$) and Older age group ($M = 6.5$ to $M = 4.37$), the interaction between age and scores was not significant. The interpretation of the interaction is illustrated in figure 8.7.

Figure 8.7:

The interaction between impulsivity and age



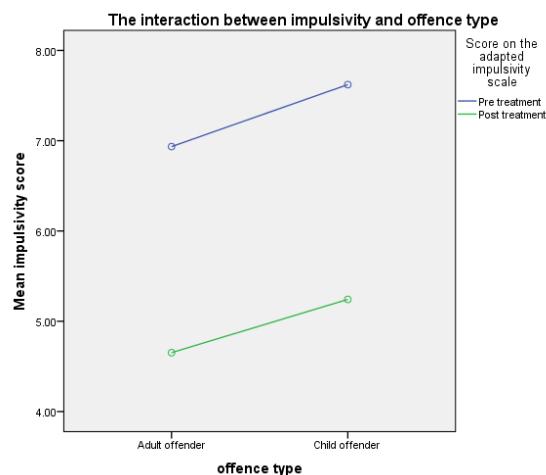
This profile plot illustrates the trend for a decrease in mean scores on the impulsivity scale across young, middle and Older age groups from pre treatment to post treatment. The trend is almost parallel. There is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the adapted impulsivity scale irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the impulsivity scale $F(1, 110) = 1.58, p > .05$. Thus, there was no significant difference in the scores of the child offenders

($M = 6.43$) compared to the adult offenders ($M = 5.79$). A significant effect for impulsivity scores pre and post treatment was obtained $F(1,110) = 39.97, p < .005$. Scores post treatment ($M = 5.0$) were significantly lower than those pre treatment ($M = 7.34$) indicating change in the desired direction which was expected. The interaction pre and post treatment scores X offence type was not significant $F(1,110) = .02, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the impulsivity scale pre to post treatment in the child offender group ($M = 7.62$ to $M = 5.24$) and in the adult offender group ($M = 6.94$ to $M = 4.65$), the interaction between offence type and impulsivity scores was not significant. The interpretation of the interaction is illustrated in figure 8.8.

Figure 8.8:

The interaction between impulsivity and offence type



This profile plot illustrates the trend for a decrease in mean scores on the impulsivity scale across both the adult offenders and child offenders groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the adapted impulsivity scale irrespective of whether they have offended against a child or an adult.

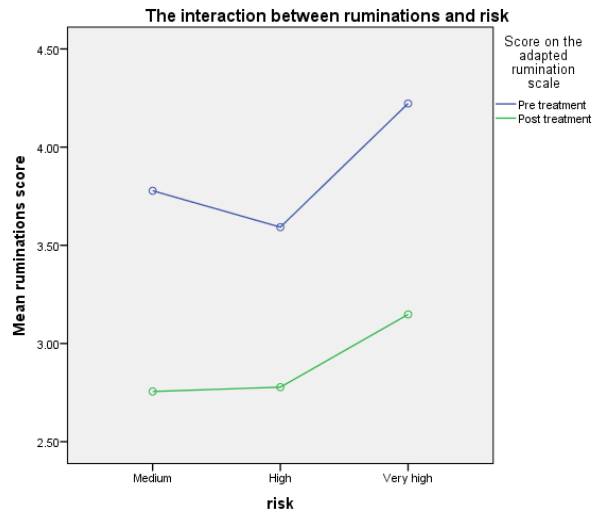
8.8.3 The Adapted Ruminations Scale: Analysis of treatment change

A series of ANOVAs were conducted to explore the relationships between risk, IQ, age of the offender and offence type and pre and post treatment scores on the adapted ruminations scale. Four mixed between subjects ANOVAs were conducted with pre and post treatment scores as the within subjects variable, and risk/ IQ/ age/ offence type as the between subjects variable. In these analysis, three effects were tested; the effects due to the between subjects variable, the effects due to the within subjects variable, and the interaction between the two factors.

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the ruminations scale $F(2, 123) = .48, p > .05$. Thus, there was no significant difference in the scores of the medium risk group ($M = 3.27$) compared to the high risk group ($M = 3.19$) and the very high risk group ($M = 3.69$). A significant effect for the ruminations scale scores pre and post treatment was obtained $F(1, 123) = 16.32, p < .01$. As expected, scores post treatment ($M = 2.85$) were significantly lower than those pre treatment ($M = 3.79$) indicating change in the desired direction. The interaction pre and post treatment scores X risk was not significant $F(2, 123) = .12, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the ruminations scale pre to post treatment in the medium risk group ($M = 3.78$ to $M = 2.76$), high risk group ($M = 3.59$ to $M = 2.78$) and very high risk group ($M = 4.22$ to $M = 3.148$), the interaction between risk and scores was not significant. The interpretation of the interaction is illustrated in figure 8.9.

Figure 8.9:

The interaction between ruminations and risk



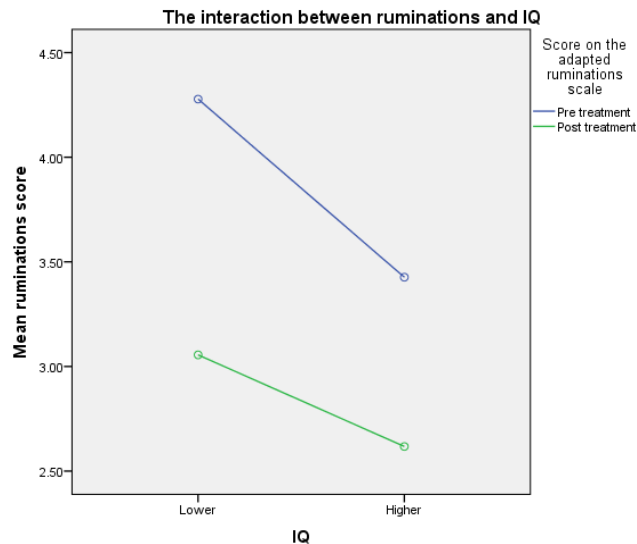
This profile plot illustrates the trend for a decrease in mean scores on the ruminations scale across medium, high and very high categories from pre treatment to post treatment. The very high risk group score more highly on rumination than the medium and high risk groups both pre and post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the adapted ruminations scale irrespective of their risk classification.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the ruminations scale $F(1, 120) = 2.62, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 3.67$) compared to the higher IQ group ($M = 3.02$). A significant effect for ruminations scores pre and post treatment was obtained $F(1, 120) = 18.63, p < .01$. Scores post treatment ($M = 2.81$) were significantly lower than those pre treatment ($M = 3.80$) indicating an expected change in the desired direction. The interaction pre and post treatment scores X IQ was not significant $F(1, 120) = .77, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the ruminations scale pre to post treatment in the lower IQ group ($M = 4.28$ to $M = 3.06$) and

the higher IQ group ($M = 3.43$ to $M = 2.62$), the interaction between IQ and scores was not significant. The interpretation of the interaction is illustrated in figure 8.10.

Figure 8.10:

The interaction between ruminations and IQ



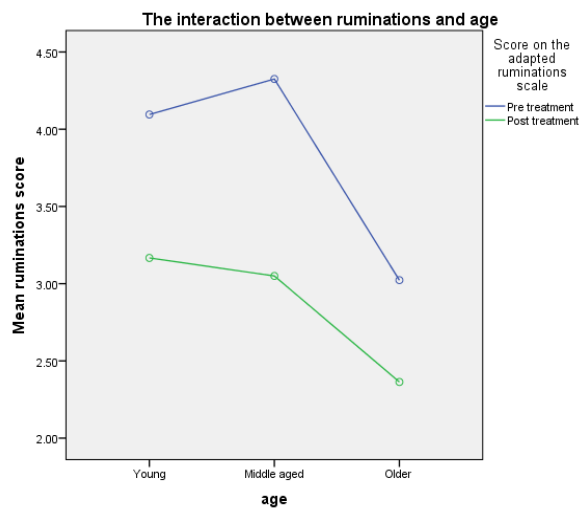
This profile plot illustrates the trend for a decrease in mean scores on the ruminations scale across the lower IQ and higher IQ groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The higher IQ group score less on the ruminations scale both pre and post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the adapted ruminations scale irrespective of their IQ classification.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the ruminations scale $F(2,123) = 2.81, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 3.63$) compared to the middle age group ($M = 3.69$) and the Older age group ($M = 2.69$). A significant effect for ruminations scores pre and post treatment was obtained $F(1,123) = 17.3, p < .01$. As expected, scores post treatment ($M = 2.85$) were significantly lower than those pre treatment ($M =$

3.79) indicating change in the desired direction. The interaction pre and post treatment scores X age was not significant $F(2,123) = .60, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the ruminations scale pre to post treatment in the young age group ($M = 4.06$ to $M = 3.17$), middle age group ($M = 4.33$ to $M = 3.05$) and older age group ($M = 3.02$ to $M = 2.36$), the interaction between age and scores was not significant. The interpretation of the interaction is illustrated in figure 8.11.

Figure 8.11:

The interaction between ruminations and age



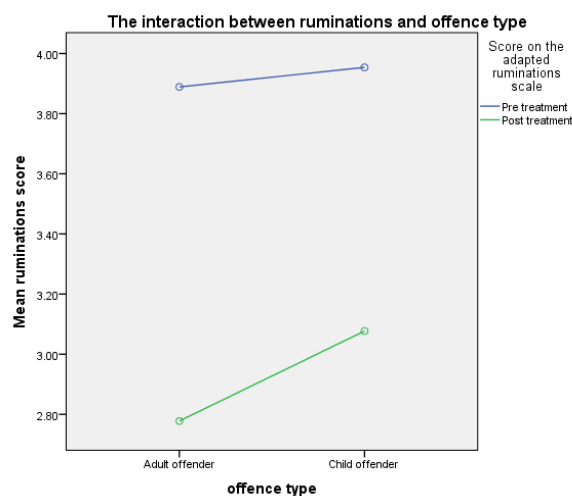
This profile plot illustrates the trend for a decrease in mean scores on the ruminations scale across young, middle and older age groups from pre treatment to post treatment. The trend is almost parallel. The older age group are less likely to ruminate both pre and post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the adapted ruminations scale irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the ruminations scale $F(1, 108) = .17, p > .05$. Thus, there was no significant difference in the scores of the child offenders (M

= 3.52) compared to the adult offenders ($M = 3.33$). A significant effect for ruminations scores pre and post treatment was obtained $F(1,108) = 14.79, p < .01$. As expected, scores post treatment ($M = 2.95$) were significantly lower than those pre treatment ($M = 3.93$) indicating change in the desired direction. The interaction pre and post treatment scores X offence type was not significant $F(1,108) = .21, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the ruminations scale pre to post treatment in the child offender group ($M = 3.95$ to $M = 3.08$) and in the adult offender group ($M = 3.89$ to $M = 2.78$), the interaction between offence type and ruminations scores was not significant. The interpretation of the interaction is illustrated in figure 8.12.

Figure 8.12:

The interaction between ruminations and offence type



This profile plot illustrates the trend for a decrease in mean scores on the ruminations scale across both the adult offenders and child offenders groups from pre treatment to post treatment. The trend is almost parallel, there is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the adapted ruminations scale irrespective of whether they have offended against a child or an adult.

8.8.4 The Adapted Relationship Style Questionnaire: Analysis of treatment change

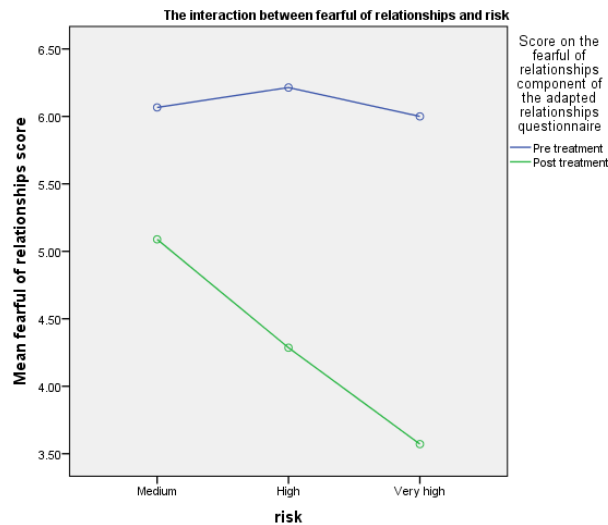
A series of ANOVAs were conducted to explore the relationships between risk, IQ, age of the offender and offence type and pre and post treatment scores on the adapted relationship styles questionnaire. Four mixed between subjects ANOVAs were conducted with pre and post treatment scores as the within subjects variable, and risk/ IQ/ age/ offence type as the between subjects variable. In these analysis, three effects were tested; the effects due to the between subjects variable, the effects due to the within subjects variable, and the interaction between the two factors.

Fearful of relationships:

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the fearful of relationships component on the relationship styles questionnaire $F(2, 126) = .48, p > .05$. Thus, there was no significant difference in the scores of the medium risk group ($M = 5.58$) compared to the high risk group ($M = 5.25$) and the very high risk group ($M = 4.79$). A significant effect for the fearful of relationships scores pre and post treatment was obtained $F(1, 126) = 31.94, p < .01$. As expected, scores post treatment ($M = 4.41$) were significantly lower than those pre treatment ($M = 6.12$) indicating change in the desired direction. The interaction pre and post treatment scores X risk was not significant $F(2, 126) = 1.75, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the fearful of relationships component pre to post treatment in the medium risk group ($M = 6.07$ to $M = 5.09$), high risk group ($M = 6.21$ to $M = 4.29$) and very high risk group ($M = 6.0$ to $M = 3.57$), the interaction between risk and scores was not significant. The interpretation of the interaction is illustrated in figure 8.13.

Figure 8.13:

The interaction between fearful of relationships and risk



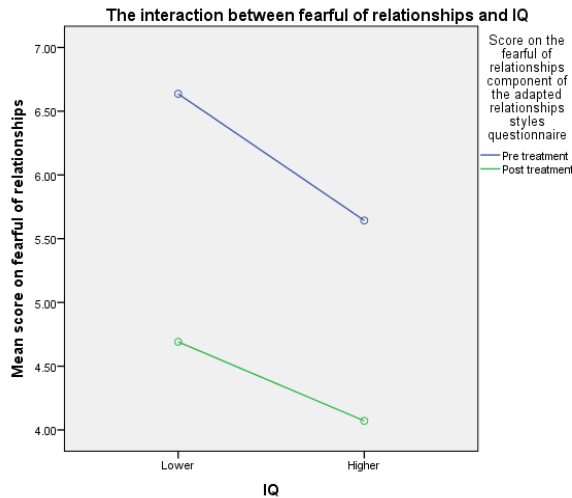
This profile plot illustrates the trend for a decrease in mean scores on the fearful of relationships component across medium, high and very high categories from pre treatment to post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the fearful of relationships component of the adapted relationship styles questionnaire irrespective of their risk classification.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the fearful of relationships component $F(1, 123) = 1.81, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 5.66$) compared to the higher IQ group ($M = 4.86$). A significant effect for fearful of relationships scores pre and post treatment was obtained $F(1, 123) = 31.41, p < .01$. Scores post treatment ($M = 4.34$) were significantly lower than those pre treatment ($M = 6.08$) indicating change in the desired direction. The interaction pre and post treatment scores X IQ was not significant $F(1, 123) = .36, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the relationship styles questionnaire pre to post treatment in the lower IQ group ($M = 6.64$ to $M = 4.69$)

and the higher IQ group ($M = 5.64$ to $M = 4.07$), the interaction between IQ and scores was not significant. The interpretation of the interaction is illustrated in figure 8.14.

Figure 8.14:

The interaction between fearful of relationships and IQ



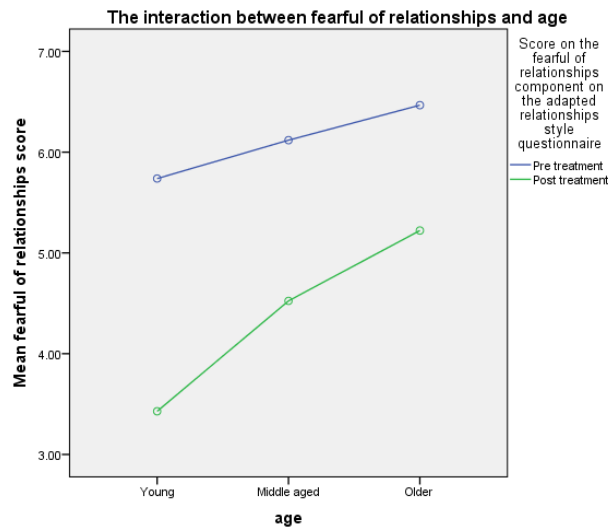
This profile plot illustrates the trend for a decrease in mean scores on the fearful of relationships component on the adapted relationship styles questionnaire across the lower IQ and higher groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The higher IQ group are less fearful of relationships than the lower IQ group at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the fearful of relationships component on the adapted relationship styles questionnaire irrespective of their IQ classification.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the relationship styles questionnaire $F(2,126) = 1.58, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 4.58$) compared to the middle age group ($M = 5.32$) and the older age group ($M = 5.84$). A significant effect for fearful of relationships scores pre and post treatment was obtained $F(1,126)$

= 31.95, $p < .01$. Scores post treatment ($M = 4.41$) were significantly lower than those pre treatment ($M = 6.12$) indicating change in the desired direction. The interaction pre and post treatment scores X age was not significant $F(2,126) = 1.07, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the fearful of relationships component pre to post treatment in the young age group ($M = 5.74$ to $M = 3.43$), middle age group ($M = 6.12$ to $M = 4.52$) and older age group ($M = 6.47$ to $M = 5.22$), the interaction between age and scores was not significant. The interpretation of the interaction is illustrated in figure 8.15.

Figure 8.15:

The interaction between fearful of relationships and IQ

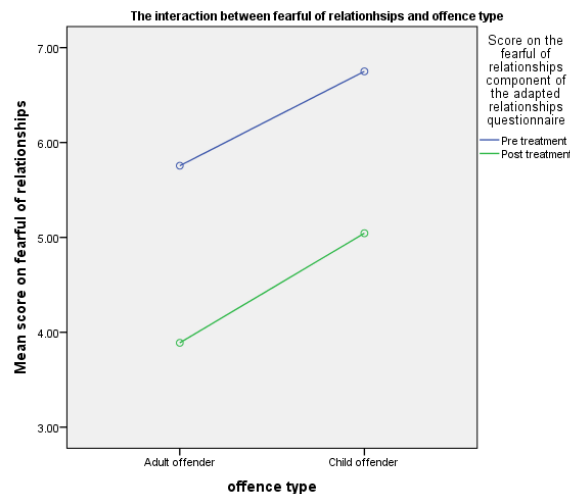


This profile plot illustrates the trend for a decrease in mean scores on the fearful of relationships component across young, middle and older age groups from pre treatment to post treatment. The trend is almost parallel. There is no interaction. The older age group score more highly on fearful of relationships at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the fearful of relationships component of the adapted relationship styles questionnaire irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the relationship styles questionnaire $F(1, 111) = 2.71, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = 5.9$) compared to the adult offenders ($M = 4.822$). A significant effect for fearful of relationships scores pre and post treatment was obtained $F(1, 111) = 28.26, p < .01$. Scores post treatment ($M = 4.58$) were significantly lower than those pre treatment ($M = 6.35$) indicating change in the desired direction. The interaction pre and post treatment scores X offence type was not significant $F(1, 111) = .06, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the relationship styles questionnaire pre to post treatment in the child offender group ($M = 6.75$ to $M = 5.04$) and in the adult offender group ($M = 5.76$ to $M = 3.89$), the interaction between offence type and fearful of relationships scores was not significant. The interpretation of the interaction is illustrated in figure 8.16.

Figure 8.16:

The interaction between fearful of relationships and offence type



This profile plot illustrates the trend for a decrease in mean scores on the fearful of relationships component across both the adult offenders and child offenders groups from pre treatment to post treatment. The trend is parallel, there is no interaction. Child offenders are

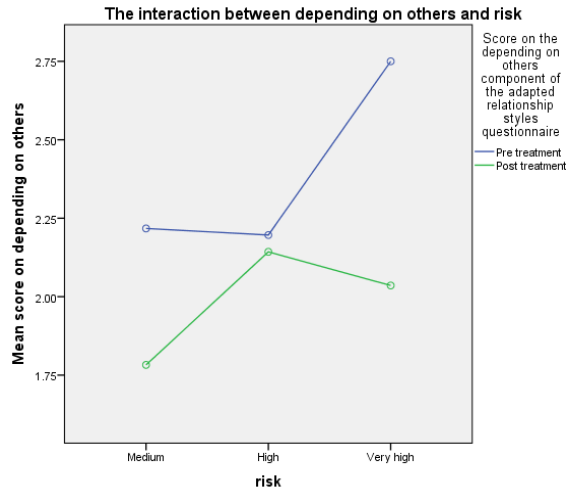
more fearful of relationships than adult offenders at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the fearful of relationships component of the adapted relationship styles questionnaire irrespective of whether they have offended against a child or an adult.

Depending on others:

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the depending on others component on the relationship styles questionnaire $F(2,127) = .66, p > .05$. Thus, there was no significant difference in the scores of the medium risk group ($M = 2.00$) compared to the high risk group ($M = 2.17$) and the very high risk group ($M = 2.39$). A significant effect for the depending on others scores pre and post treatment was obtained $F(1,127) = 9.04, p < .05$. Scores post treatment ($M = 1.99$) were significantly lower than those pre treatment ($M = 2.32$) indicating change in the desired direction. The interaction pre and post treatment scores X risk was not significant $F(2,127) = 2.1, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the depending on others component pre to post treatment in the medium risk group ($M = 2.22$ to $M = 1.78$), high risk group ($M = 2.2$ to $M = 2.14$) and very high risk group ($M = 2.75$ to $M = 2.04$), the interaction between risk and scores was not significant. The interpretation of the interaction is illustrated in figure 8.17.

Figure 8.17:

The interaction between depending on others and risk



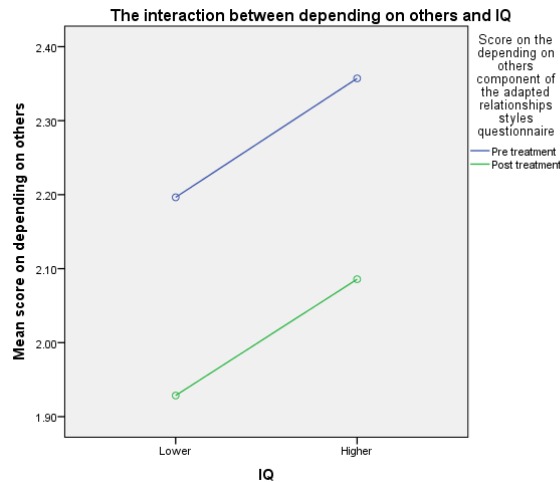
This profile plot illustrates the trend for a decrease in mean scores on the depending on others component across medium, high and very high categories from pre treatment to post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the depending on others component of the adapted relationship styles questionnaire irrespective of their risk classification.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the depending on others component $F(1, 124) = .38, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 2.06$) compared to the higher IQ group ($M = 2.22$). A significant effect for depending on others scores pre and post treatment was obtained $F(1, 124) = 4.30, p < .05$. Scores post treatment ($M = 2.02$) were significantly lower than those pre treatment ($M = 2.29$) indicating change in the desired direction. The interaction pre and post treatment scores X IQ was not significant $F(1, 124) = .000, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the relationship styles questionnaire pre to post treatment in the lower IQ group ($M = 2.2$ to $M = 1.93$)

and the higher IQ group ($M = 2.36$ to $M = 2.09$), the interaction between IQ and scores was not significant. The interpretation of the interaction is illustrated in figure 8.18.

Figure 8.18:

The interaction between depending on others and IQ



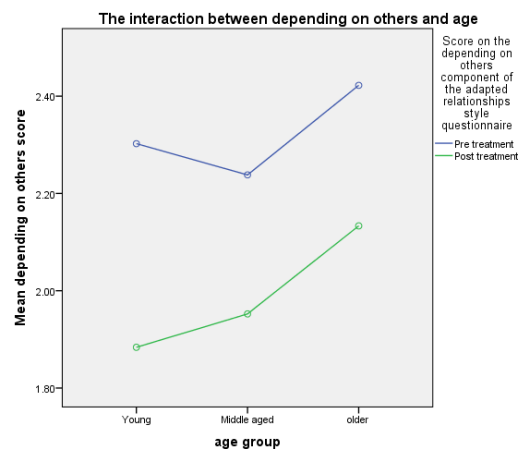
This profile plot illustrates the trend for a decrease in mean scores on the depending on others component on the adapted relationship styles questionnaire across the lower IQ and higher IQ groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The high IQ group score more highly on depending on others than the lower IQ group. The analysis supports the hypothesis that treatment participants show change in the desired direction on the depending on others component on the adapted relationship styles questionnaire irrespective of their IQ classification.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the depending on others component of the relationship styles questionnaire $F(2,127) = .24, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 2.09$) compared to the middle age group ($M = 2.1$) and the older age group ($M = 2.28$). A significant effect for depending on others scores pre and post

treatment was obtained $F(1,127) = 6.5, p < .05$. Scores post treatment ($M = 1.99$) were significantly lower than those pre treatment ($M = 2.32$) indicating change in the desired direction. The interaction pre and post treatment scores X age was not significant $F(2,127) = .11, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the depending on others component pre to post treatment in the young age group ($M = 2.32$ to $M = 1.88$), middle age group ($M = 2.24$ to $M = 1.95$) and older age group ($M = 2.42$ to $M = 2.13$), the interaction between age and scores was not significant. The interpretation of the interaction is illustrated in figure 8.19.

Figure 8.19:

The interaction between depending on others and age

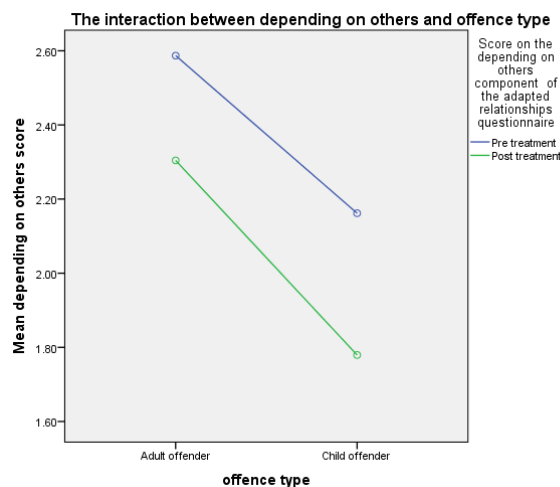


This profile plot illustrates the trend for a decrease in mean scores on the depending on others component across young, middle and older age groups from pre treatment to post treatment. There is no interaction. The older age group are score more highly on depending on others than both the young and middle aged group. The analysis supports the hypothesis that treatment participants show change in the desired direction on the depending on others component of the adapted relationship styles questionnaire irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the depending on others component of the relationship styles questionnaire $F(1, 112) = 3.01, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = 1.97$) compared to the adult offenders ($M = 2.45$). A significant effect for depending on others scores pre and post treatment was obtained $F(1, 112) = 5.36, p < .05$. Scores post treatment ($M = 1.99$) were significantly lower than those pre treatment ($M = 2.33$) indicating change in the desired direction. The interaction pre and post treatment scores X offence type was not significant $F(1, 112) = .12, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the relationship styles questionnaire pre to post treatment in the child offender group ($M = 2.16$ to $M = 1.78$) and in the adult offender group ($M = 2.59$ to $M = 2.30$), the interaction between offence type and depending on others scores was not significant. The interpretation of the interaction is illustrated (figure 8.20).

Figure 8.20:

The interaction between depending on others and offence type



This profile plot illustrates the trend for a decrease in mean scores on the depending on others component across both the adult offenders and child offenders groups from pre treatment to post

treatment. The trend is parallel, there is no interaction. The adult offenders score more highly on depending on others than the child offender group. The analysis supports the hypothesis that treatment participants show change in the desired direction on the depending on others component of the adapted relationship styles questionnaire irrespective of whether they have offended against a child or an adult.

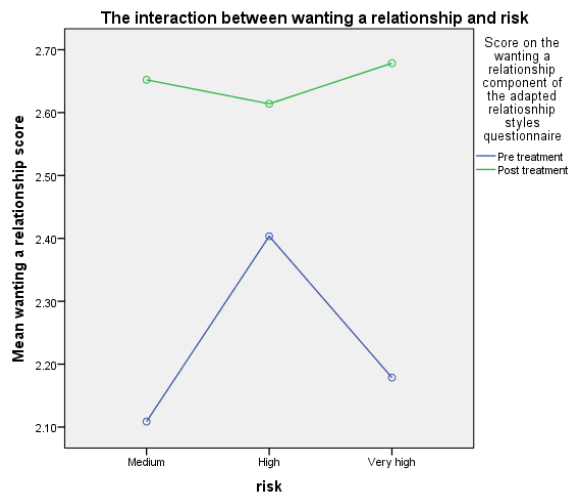
Wanting a relationship:

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the wanting a relationship component of the relationship styles questionnaire $F(2,128) = .34, p > .05$. Thus, there was no significant difference in the scores of the medium risk group ($M = 2.38$) compared to the high risk group ($M = 2.51$) and the very high risk group ($M = 2.43$). A significant effect for the wanting a relationship scores pre and post treatment was obtained $F(1,128) = 20.66, p < .01$. Scores post treatment ($M = 2.64$) were significantly higher than those pre treatment ($M = 2.25$) indicating change in the desired direction.

The interaction pre and post treatment scores X risk was not significant $F(2,128) = 1.61, p > .05$. Examination of the cell means indicated that although there was an increase in scores on wanting a relationship scale pre to post treatment in the medium risk group ($M = 2.11$ to $M = 2.65$), high risk group ($M = 2.40$ to $M = 2.61$) and very high risk group ($M = 2.18$ to $M = 2.68$), the interaction between risk and scores was not significant. The interpretation of the interaction is illustrated in figure 8.21.

Figure 8.21:

The interaction between wanting a relationship and risk



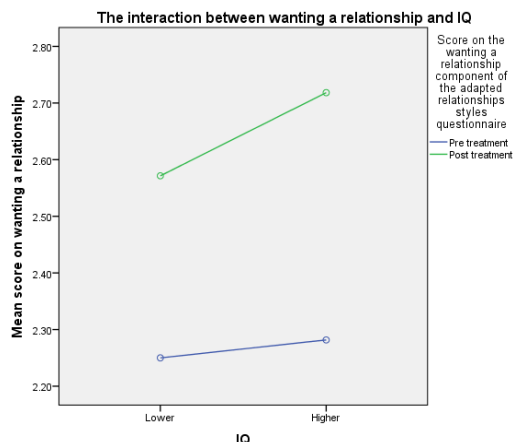
This profile plot illustrates the trend for an increase in mean scores on the wanting a relationship component across medium, high and very high categories from pre treatment to post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the wanting a relationship component of the adapted relationship styles questionnaire irrespective of their risk classification.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the wanting a relationship component of the adapted relationship style questionnaire $F(1, 125) = .41, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 2.41$) compared to the higher IQ group ($M = 2.50$). A significant effect for wanting a relationship scores pre and post treatment was obtained $F(1, 125) = 17.61, p < .01$. Scores post treatment ($M = 2.65$) were significantly higher than those pre treatment ($M = 2.27$) indicating change in the desired direction. The interaction pre and post treatment scores X IQ was not significant $F(1, 125) = .41, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the wanting a relationships component pre to post treatment in the lower IQ group ($M = 2.25$ to $M = 2.57$) and the higher IQ group ($M =$

2.28 to $M = 2.72$), the interaction between IQ and scores was not significant. The interpretation of the interaction is illustrated in figure 8.22.

Figure 8.22:

The interaction between wanting a relationship and IQ



This profile plot illustrates the trend for an increase in mean scores on the wanting a relationship component across the lower IQ and higher IQ groups from pre treatment to post treatment. The trend is almost parallel, there is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the wanting a relationship component of the adapted relationship styles questionnaire irrespective of their IQ classification.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the wanting a relationship component of the relationship styles questionnaire $F(2,128) = 2.58, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 2.61$) compared to the middle age group ($M = 2.49$) and the older age group ($M = 2.24$). A significant effect for wanting a relationship scores pre and post treatment was obtained $F(1,128) = 19.22, p < .01$. Scores post treatment ($M = 2.64$) were significantly higher than those pre treatment ($M = 2.25$) indicating change in the desired direction.

The interaction pre and post treatment scores X age was not significant $F(2,128) = .19, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the wanting a relationship component pre to post treatment in the young age group ($M = 2.46$ to $M = 2.77$), middle age group ($M = 2.26$ to $M = 2.71$) and older age group ($M = 2.04$ to $M = 2.44$), the interaction between age and scores was not significant. The interpretation of the interaction is illustrated in figure 8.23.

Figure 8.23:

The interaction between wanting a relationship and age



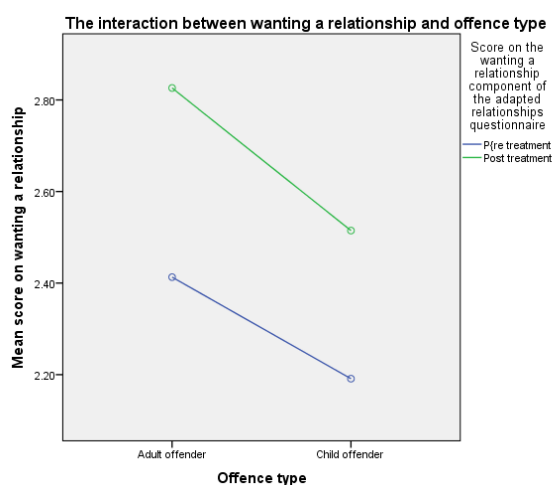
This profile plot illustrates the trend for an increase in mean scores on the wanting a relationship component across young, middle and older age groups from pre treatment to post treatment. The trend is almost parallel, there is no interaction. Wanting a relationship appears to decline with age at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the wanting a relationship component of the adapted relationship styles questionnaire irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the wanting a relationship component of the relationship styles questionnaire $F(1, 112) = 3.12, p > .05$. Thus, there was no

significant difference in the scores of the child offenders ($M = 2.36$) compared to the adult offenders ($M = 2.62$). A significant effect for wanting a relationship scores pre and post treatment was obtained $F(1,112) = 15.72, p < .01$. Scores post treatment ($M = 2.64$) were significantly higher than those pre treatment ($M = 2.28$) indicating change in the desired direction. The interaction pre and post treatment scores X offence type was not significant $F(1,112) = .23, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the wanting a relationship component pre to post treatment in the child offender group ($M = 2.19$ to $M = 2.52$) and in the adult offender group ($M = 2.41$ to $M = 2.83$), the interaction between offence type and wanting a relationship scores was not significant. The interpretation of the interaction is illustrated in figure 8.24.

Figure 8.24:

The interaction between wanting a relationship and offence type



This profile plot illustrates the trend for an increase in mean scores on the wanting a relationship scores across both the adult offenders and child offenders groups from pre treatment to post treatment. The trend is parallel, there is no interaction. Adult offenders are more likely to want a relationship than child offenders at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the

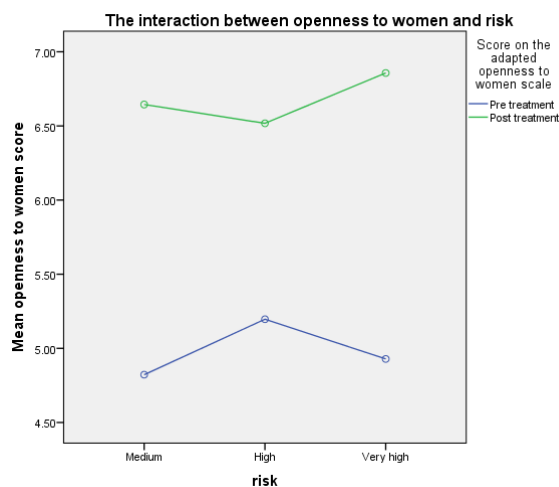
wanting a relationship component of the adapted relationship styles questionnaire irrespective of whether they have offended against a child or an adult.

8.8.5 The Adapted Openness to Women Scale: Analysis of treatment change

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the openness to women scale $F(2,126) = .18, p > .05$. Thus, there was no significant difference in the scores of the medium risk group ($M = 5.73$) compared to the high risk group ($M = 5.86$) and the very high risk group ($M = 5.89$). A significant effect for the openness to women score pre and post treatment was obtained $F(1,126) = 81.5, p < .01$. Scores post treatment ($M = 6.64$) were significantly higher than those pre treatment ($M = 5.01$) indicating change in the desired direction. The interaction pre and post treatment scores X risk was not significant $F(2,126) = 1.14, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the openness to women scale pre to post treatment in the medium risk group ($M = 4.82$ to $M = 6.64$), high risk group ($M = 5.2$ to $M = 6.52$) and very high risk group ($M = 4.93$ to $M = 6.86$), the interaction between risk and scores was not significant. The interpretation of the interaction is illustrated in figure 8.25.

Figure 8.25:

The interaction between openness to women and risk



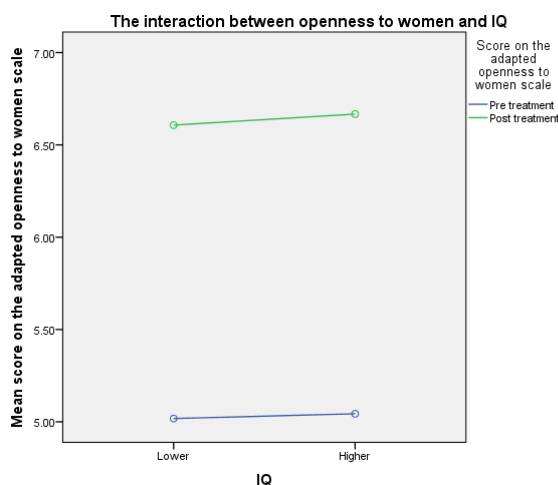
This profile plot illustrates the trend for an increase in mean scores on the openness to women scale across medium, high and very high categories from pre treatment to post treatment. The

very high risk group appear to make the most shift in treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the openness to women scale irrespective of their risk classification.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the openness to women scale $F(1, 123) = .04, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 5.73$) compared to the higher IQ group ($M = 5.86$). A significant effect for openness to women scores pre and post treatment was obtained $F(1, 123) = 76.38, p < .01$. Scores post treatment ($M = 6.64$) were significantly higher than those pre treatment ($M = 5.03$) indicating change in the desired direction. The interaction pre and post treatment scores X IQ was not significant $F(1, 123) = .01, p < .05$. Examination of the cell means indicated that there was an increase in scores on the openness to women scale pre to post treatment in the lower IQ group ($M = 5.02$ to $M = 6.61$) and the higher IQ group ($M = 5.04$ to $M = 6.67$), the interaction between IQ and scores was not significant. The interpretation of the interaction is illustrated in figure 8.26.

Figure 8.26:

The interaction between openness to women and IQ

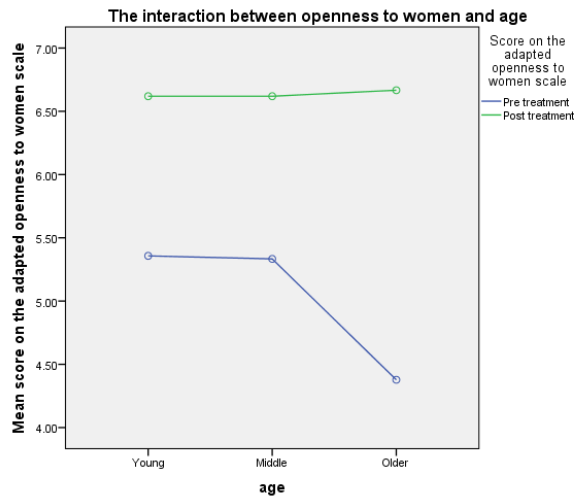


This profile plot illustrates the trend for an increase in mean scores on the openness to women scale across the lower IQ and higher IQ groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the openness to women scale irrespective of their IQ classification.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on openness to women scale $F(2,126) = 2.08, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 5.99$) compared to the middle age group ($M = 5.98$) and the older age group ($M = 5.52$). A significant effect for wanting a relationship scores pre and post treatment was obtained $F(1,126) = 83.74, p < .01$. Scores post treatment ($M = 6.64$) were significantly higher than those pre treatment ($M = 5.01$) indicating change in the desired direction. The interaction pre and post treatment openness to women scores X age was significant $F(2,126) = 3.78, p < .05$. Examination of the cell means indicated that there was an increase in scores on the openness to women scale pre to post treatment in the young age group ($M = 5.36$ to $M = 6.62$), middle age group ($M = 5.33$ to $M = 6.62$) and older age group ($M = 4.38$ to $M = 6.67$). The interpretation of the interaction is illustrated in figure 8.27.

Figure 8.27:

The interaction between openness to women and age



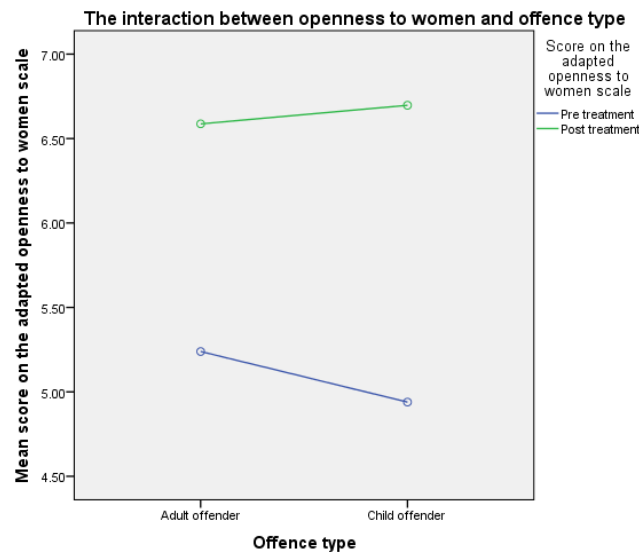
This profile plot illustrates the trend for an increase in mean scores on the openness to women scale across young, middle and older age groups from pre treatment to post treatment. The interaction between scores on the openness to women scale and age was significant. Pre treatment the older age group's scores on openness to women are significantly lower than the young and middle age groups. Post treatment, all 3 age groups score similarly on openness to women. The analysis supports the hypothesis that treatment participants show change in the desired direction on the openness to women scale of the adapted relationship styles questionnaire irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the openness to women scale $F(1, 110) = .16, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = 5.81$) compared to the adult offenders ($M = 5.91$). A significant effect for openness to women scores pre and post treatment was obtained $F(1, 110) = 68.7, p < .01$. Scores post treatment ($M = 6.65$) were significantly higher than those pre treatment ($M = 5.06$) indicating change in the desired direction. The interaction pre and post treatment scores X offence type was

not significant $F(1,110) = 1.2, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the openness to women scale pre to post treatment in the child offender group ($M = 4.94$ to $M = 6.7$) and in the adult offender group ($M = 5.24$ to $M = 6.59$), the interaction between offence type and openness to women scores was not significant. The interpretation of the interaction is illustrated in figure 8.28.

Figure 8.28:

The interaction between openness to women and offence type



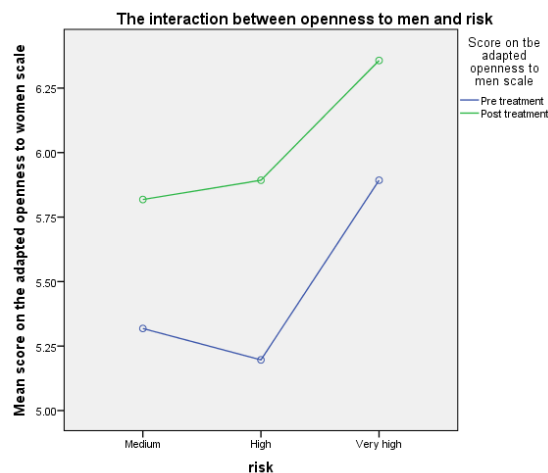
This profile plot illustrates the trend for an increase in mean scores on the openness to women scale across both the adult offenders and child offenders groups from pre treatment to post treatment. There is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the openness to women scale questionnaire irrespective of whether they have offended against a child or an adult.

8.8.6 The Adapted Openness to Men Scale: Analysis of treatment change

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the openness to men scale $F(2,125) = 1.59$, $p > .05$. Thus, there was no significant difference in the scores of the medium risk group ($M = 5.56$) compared to the high risk group ($M = 5.55$) and the very high risk group ($M = 6.13$). A significant effect for the openness to men scores pre and post treatment was obtained $F(1,125) = 13.7$, $p < .01$. Scores post treatment ($M = 5.97$) were significantly higher than those pre treatment ($M = 5.39$) indicating change in the desired direction. The interaction pre and post treatment scores X risk was not significant $F(2,125) = .27$, $p > .05$. Examination of the cell means indicated that although there was an increase in scores on the openness to men scale pre to post treatment in the medium risk group ($M = 5.32$ to $M = 5.82$), high risk group ($M = 5.2$ to $M = 5.89$) and very high risk group ($M = 5.39$ to $M = 6.36$), the interaction between risk and scores was not significant. The interpretation of the interaction is illustrated in figure 8.29.

Figure 8.29:

The interaction between openness to men and risk



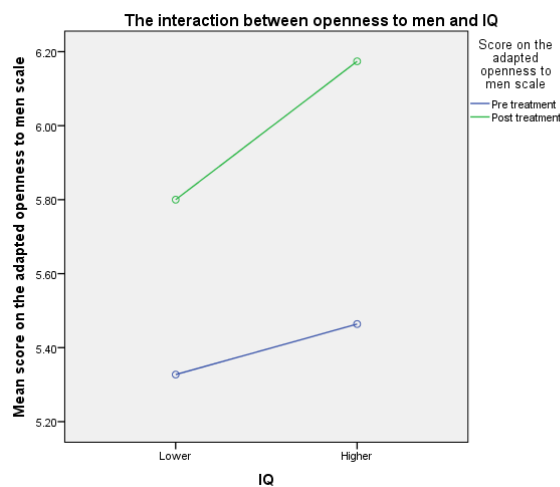
This profile plot illustrates the trend for an increase in mean scores on the openness to men scale across medium, high and very high categories from pre treatment to post treatment. The

trend is parallel, there is no interaction. The very high risk group score more highly on openness to men at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the openness to men scale irrespective of their risk classification.

IQ; The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the openness to men scale $F(1, 122) = .91, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 5.56$) compared to the higher IQ group ($M = 5.82$). A significant effect for openness to men scores pre and post treatment was obtained $F(1, 122) = 16.23, p < .01$. Scores post treatment ($M = 6.01$) were significantly higher than those pre treatment ($M = 5.4$) indicating change in the desired direction. The interaction pre and post treatment scores X IQ was not significant $F(1, 122) = .65, p > .05$. Examination of the cell means indicated that although there was a increase in scores on the openness to men scale pre to post treatment in the lower IQ group ($M = 5.33$ to $M = 5.8$) and the higher IQ group ($M = 5.46$ to $M = 6.17$), the interaction between IQ and scores was not significant. The interpretation of the interaction is illustrated in figure 8.30.

Figure 8.30:

The interaction between openness to men and IQ

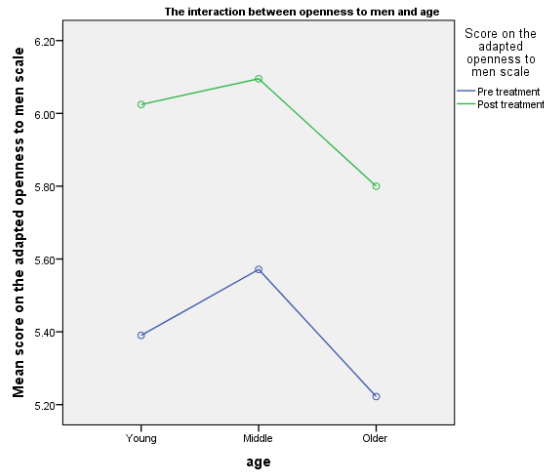


This profile plot illustrates the trend for an increase in mean scores on the openness to men scale across the lower IQ and higher IQ groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The higher IQ group score more highly on openness to men at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the openness to men scale irrespective of their IQ classification.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on openness to men scale $F(2,125) = .51, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 5.71$) compared to the middle age group ($M = 5.83$) and the older age group ($M = 5.51$). A significant effect for openness to men scores pre and post treatment was obtained $F(1,125) = 16.16, p < .01$. Scores post treatment ($M = 5.97$) were significantly higher than those pre treatment ($M = 5.39$) indicating change in the desired direction. The interaction pre and post treatment openness to men scores X age was not significant $F(2,125) = .48, p > .05$. Examination of the cell means indicated that there was an increase in scores on the openness to women scale pre to post treatment in the young age group ($M = 5.39$ to $M = 6.02$), middle age group ($M = 5.57$ to $M = 6.1$) and older age group ($M = 5.22$ to $M = 5.8$). The interpretation of the interaction is illustrated in figure 8.31.

Figure 8.31:

The interaction between openness to men and age



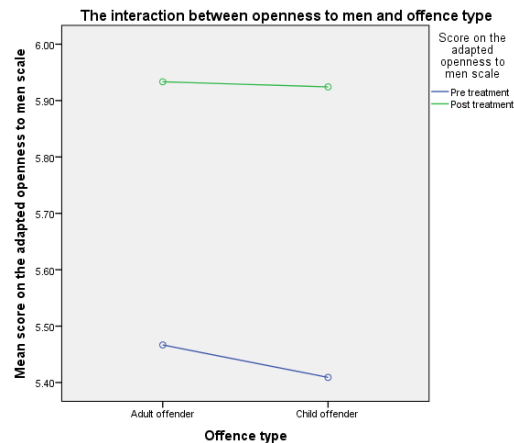
This profile plot illustrates the trend for an increase in mean scores on the openness to men scale across young, middle and older age groups from pre treatment to post treatment. There is no interaction. The older age group score less than both the young and middle aged group at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the openness to men scale irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the openness to men scale $F(1, 109) = .01, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = 5.67$) compared to the adult offenders ($M = 5.7$). A significant effect for openness to men scores pre and post treatment was obtained $F(1, 109) = 9.38, p < .05$. Scores post treatment ($M = 5.93$) were significantly higher than those pre treatment ($M = 5.43$) indicating change in the desired direction. The interaction pre and post treatment scores X offence type was not significant $F(1, 109) = .02, p > .05$. Examination of the cell means indicated that although there was an increase in scores on the openness to men scale pre to post treatment in the child offender

group ($M = 5.41$ to $M = 5.92$) and in the adult offender group ($M = 5.46$ to $M = 5.93$), the interaction between offence type and openness to men scores was not significant. The interpretation of the interaction is illustrated in figure 8.32.

Figure 8.32:

The interaction between openness to men and offence type



This profile plot illustrates the trend for an increase in mean scores on the openness to men scale across both the adult offenders and child offenders groups from pre treatment to post treatment. There is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the openness to men scale questionnaire irrespective of whether they have offended against a child or an adult.

8.8.7. The Sex offender Opinions Test: Analysis of treatment change

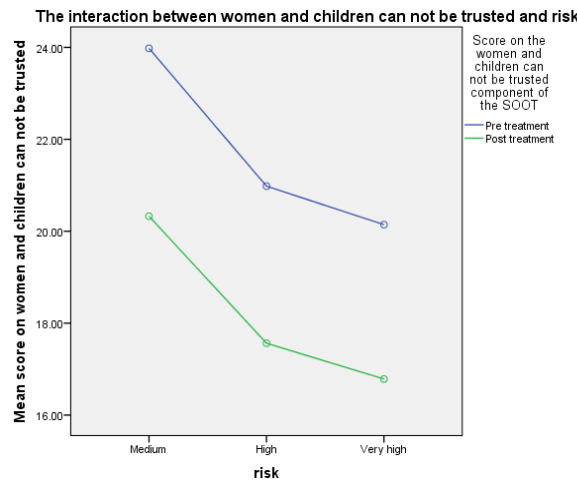
A series of ANOVAs were conducted to explore the relationships between risk, IQ, age of the offender and offence type and pre and post treatment scores on each of the newly formed components of the SOOT. Four mixed between subjects ANOVAs were conducted with pre and post treatment scores on each component of the SOOT as the within subjects variable, and risk/ IQ/ age/ offence type as the between subjects variable. In these analysis, three effects were tested; the effects due to the between subjects variable, the effects due to the within subjects variable, and the interaction between the two factors.

Analysis of the “women and children can not be trusted” component:

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was significant on scores on the “women and children can not be trusted” component $F(2, 126) = 4.76, p < .05$. Thus, there was a significant difference in the scores of the medium risk group ($M = 22.15$) compared to the high risk group ($M = 19.27$) and the very high risk group ($M = 18.46$). A significant effect for “women and children can not be trusted” scores pre and post treatment was obtained $F(1, 126) = 37.47, p < .05$. Scores post treatment ($M = 18.38$) were significantly lower than those pre treatment ($M = 21.87$). The interaction pre and post treatment scores X risk was not significant $F(2, 126) = .03, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the “women and children cannot be trusted” component pre to post treatment in the medium risk group ($M = 23.98$ to $M = 20.33$), high risk group ($M = 20.98$ to $M = 17.56$) and very high risk group ($M = 20.14$ to $M = 16.79$), the interaction between risk and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.33.

Figure 8.33:

The interaction between “women and children can not be trusted” and risk



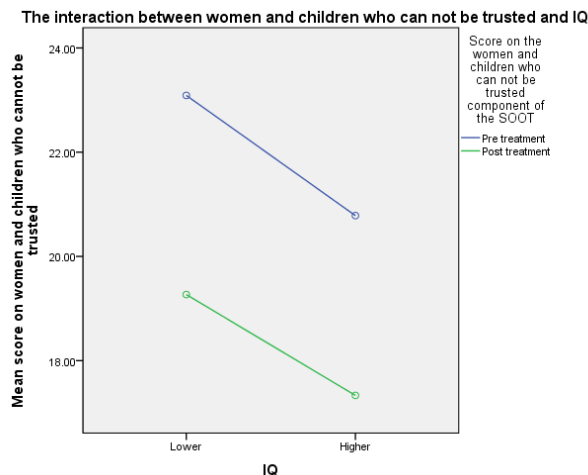
This profile plot illustrates the trend for a decrease in mean scores on the “women and children can not be trusted” component of the SOOT across medium, high and very high categories from pre treatment to post treatment. The trend is almost parallel, there is no interaction. The medium risk group score significantly more highly than the high and very high risk group at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the women and children component of the SOOT irrespective of their risk classification.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was significant on scores on the “women and children can not be trusted” component $F(1, 123) = 4.47, p < .05$. Thus, there was a significant difference in the scores of the lower IQ group ($M = 21.18$) compared to the higher IQ group ($M = 19.06$). A significant effect for “women and children can not be trusted” scores pre and post treatment was obtained $F(1, 123) = 42.63, p < .05$. Scores post treatment ($M = 18.20$) were significantly lower than those pre treatment ($M = 21.82$). The interaction pre and post treatment scores X IQ was not significant $F(1, 123) = .11, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on

the women and children cannot be trusted component pre to post treatment in the lower IQ group ($M = 23.09$ to $M = 19.27$) and the higher IQ group ($M = 20.78$ to $M = 17.33$), the interaction between IQ and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.34.

Figure 8.34:

The interaction between “women and children can not be trusted” and IQ



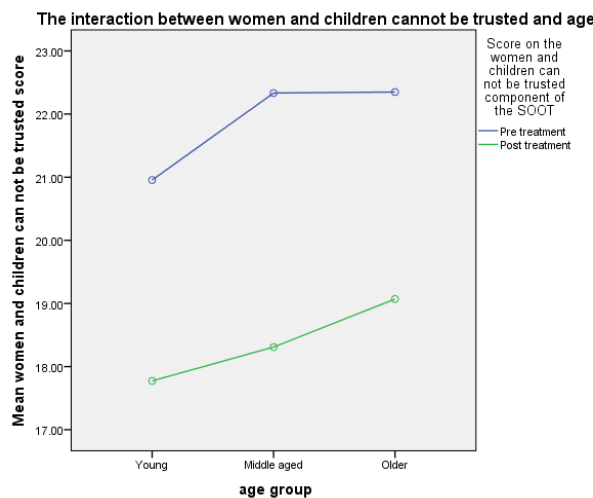
This profile plot illustrates the trend for a decrease in mean scores on the “women and children can not be trusted” component of the SOOT across the lower IQ and higher IQ groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The lower IQ group score significantly more highly at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the women and children component of the SOOT irrespective of their IQ level.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the “women and children can not be trusted” component $F(2, 126) = .61, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 19.36$) compared to the middle age group ($M = 20.32$) and the older age group ($M = 20.71$). A significant effect for “women and children can not be trusted” scores pre

and post treatment was obtained $F(1,126) = 41.19, p < .01$. Scores post treatment ($M = 18.38$) were significantly lower than those pre treatment ($M = 21.87$). The interaction pre and post treatment scores X age was not significant $F(2,126) = .24, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the women and children cannot be trusted component pre to post treatment in the young age group ($M = 20.96$ to $M = 17.77$), middle age group ($M = 22.33$ to $M = 18.31$) and older age group ($M = 22.35$ to $M = 19.07$), the interaction between age and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.35.

Figure 8.35:

The interaction between “women and children can not be trusted” and age

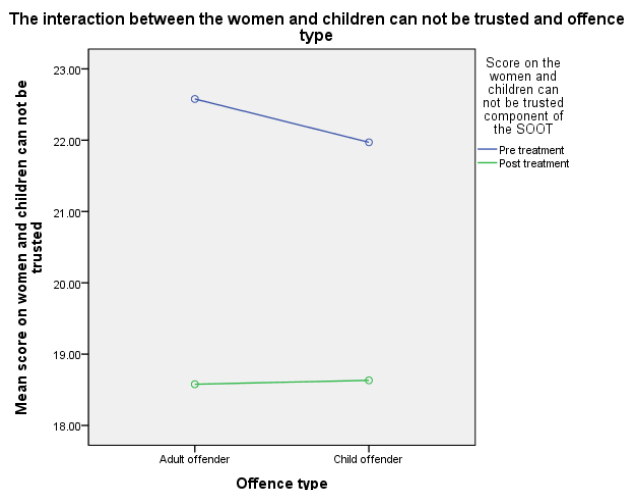


This profile plot illustrates the trend for a decrease in mean scores on the “women and children can not be trusted” component of the SOOT across young, middle and older age groups from pre treatment to post treatment. The trend confirms that the young age group hold less “women and children can not be trusted” distortions than middle and older men both pre treatment and post treatment. There is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the women and children component of the SOOT irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the “women and children can not be trusted” component $F(1, 111) = .06, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = 20.58$) compared to the adult offenders ($M = 20.30$). A significant effect for “women and children can not be trusted” scores pre and post treatment was obtained $F(1,111) = 37.25, p < .05$. Scores post treatment ($M = 18.61$) were significantly lower than those pre treatment ($M = 22.21$). The interaction pre and post treatment scores X offence type was not significant $F(1,111) = .30, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the women and children cannot be trusted component pre to post treatment in the child offender group ($M = 22.58$ to $M = 18.58$) and in the adult offender group ($M = 21.97$ to $M = 18.63$), the interaction between offence type and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.36.

Figure 8.36:

The interaction between “women and children can not be trusted” and offence type



This profile plot illustrates the trend for a decrease in mean scores on the “women and children can not be trusted” component of the SOOT across both the adult offenders and child offenders groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The

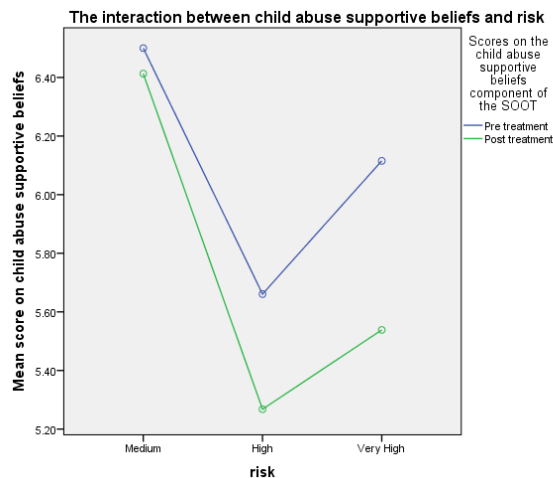
analysis supports the hypothesis that treatment participants show change in the desired direction on the women and children component of the SOOT irrespective of whether they offended against an adult or a child.

Analysis of the “child abuse supportive” beliefs component.

Risk; A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was significant on scores on the “child abuse supportive” beliefs component $F(1, 125) = 3.25, p < .05$. Thus, there was a significant difference in the scores of the medium risk group ($M = 6.46$) compared to the high risk group ($M = 5.46$) and the very high risk group ($M = 5.83$). There was no significant effect for “child abuse supportive” beliefs scores pre and post treatment $F(1, 125) = 3.24, p > .05$. Scores post treatment ($M = 5.73$) were not significantly lower than those pre treatment ($M = 6.05$). The interaction pre and post treatment scores X risk was not significant $F(2, 125) = .51, p > .05$. Examination of the cell means indicated that although there was a slight decrease in scores on the “child abuse supportive” beliefs component pre to post treatment in the medium risk group ($M = 6.5$ to $M = 6.41$), high risk group ($M = 5.66$ to $M = 5.27$) and very high risk group ($M = 6.12$ to $M = 5.54$), the interaction between risk and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.37.

Figure 8.37:

The interaction between “child abuse supportive” beliefs and risk



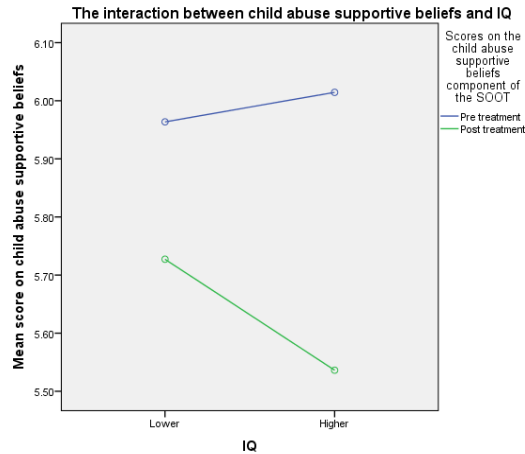
This profile plot illustrates a non significant trend for a decrease in mean scores on the “child abuse supportive” beliefs component of the SOOT across medium, high and very high categories from pre treatment to post treatment. The analysis does not support the hypothesis that treatment participants show significant change in the desired direction on the “child abuse supportive” beliefs component of the SOOT irrespective of their risk classification.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the “child abuse supportive” beliefs component $F(1, 122) = .05, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 5.85$) compared to the higher IQ group ($M = 5.78$). A non significant effect for “child abuse supportive” beliefs scores pre and post treatment was obtained $F(1, 122) = 3.72, p > .05$. Scores post treatment ($M = 5.62$) were not significantly lower than those pre treatment ($M = 5.99$). The interaction pre and post treatment scores X IQ was not significant $F(1, 122) = .43, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the “child abuse supportive” beliefs component pre to post treatment in the lower IQ group ($M = 5.96$ to $M = 5.72$) and the higher IQ group ($M = 6.01$ to $M = 5.53$), the interaction between IQ and

scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.38.

Figure 8.38:

The interaction between “child abuse supportive” beliefs and IQ



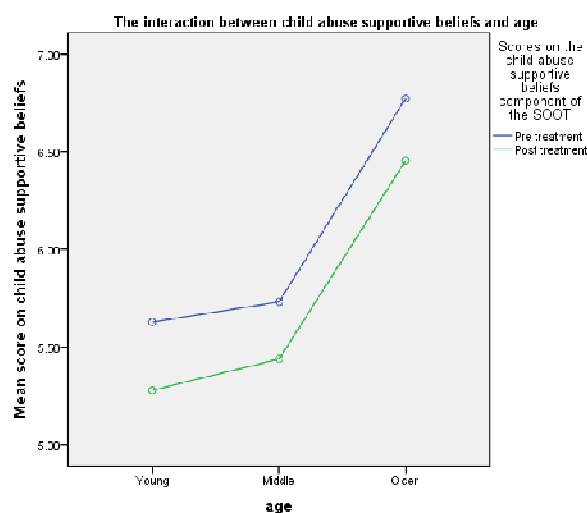
This profile plot illustrates the non significant trend for a decrease in mean scores on the “child abuse supportive” beliefs component of the SOOT across the lower IQ and higher IQ groups from pre treatment to post treatment. There is no interaction. The analysis does not support the hypothesis that treatment participants show significant change in the desired direction on the “child abuse supportive” beliefs component of the SOOT irrespective of their IQ level.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed a significant effect for age on scores on the “child abuse supportive” beliefs component $F(1, 125) = 4.65, p < .05$. Thus, there was a significant difference in the scores of the young age group ($M = 5.45$) compared to the middle age group ($M = 5.56$) and the older age group ($M = 6.61$). A non significant effect for “child abuse supportive” beliefs scores pre and post treatment was obtained $F(1, 125) = 2.94, p > .05$. Scores post treatment ($M = 6.04$) were not significantly lower than those pre treatment ($M = 5.72$). The interaction pre and post treatment scores X age was not significant $F(2, 125) = .01, p > .05$. Examination of the cell means indicated that although

there was a decrease in scores on “child abuse supportive beliefs” component pre to post treatment in the young age group ($M = 5.63$ to $M = 5.28$), middle age group ($M = 5.73$ to $M = 5.44$) and older age group ($M = 6.77$ to $M = 6.45$), the interaction between age and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.39.

Figure 8.39:

The interaction between “child abuse supportive” beliefs and age



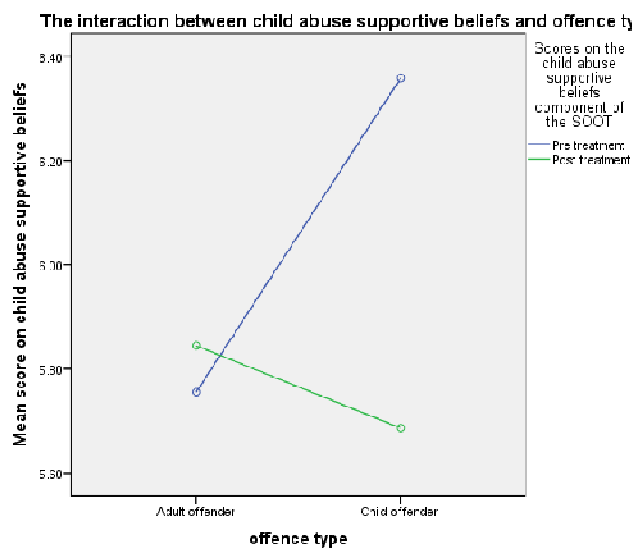
This profile plot illustrates the non significant trend for a decrease in mean scores on the “child abuse supportive” beliefs component of the SOOT across young, middle and older age groups from pre treatment to post treatment. The analysis does not support the hypothesis that treatment participants show significant change in the desired direction on the “child abuse supportive” beliefs component of the SOOT irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the “child abuse supportive” beliefs component $F(1, 110) = .31, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = 6.02$) compared to the adult offenders ($M = 5.80$). No significant effects for “child abuse supportive” beliefs pre and post treatment were obtained F

(1,110) = 1.99, $p > .05$. Scores post treatment ($M = 5.77$) were not significantly lower than those pre treatment ($M = 6.06$). The interaction pre and post treatment scores X offence type was not significant $F(1,110) = 3.4$, $p > .05$. Examination of the cell means indicated that there was an increase in scores on the “child abuse supportive” beliefs component pre to post treatment in the adult offender group ($M = 5.76$ to $M = 5.84$), but a decrease of pre treatment to post treatment scores in the child offender group ($M = 6.36$ to $M = 5.69$). The interaction between offence type and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.40.

Figure 8.40:

The interaction between “child abuse supportive” beliefs and offence type



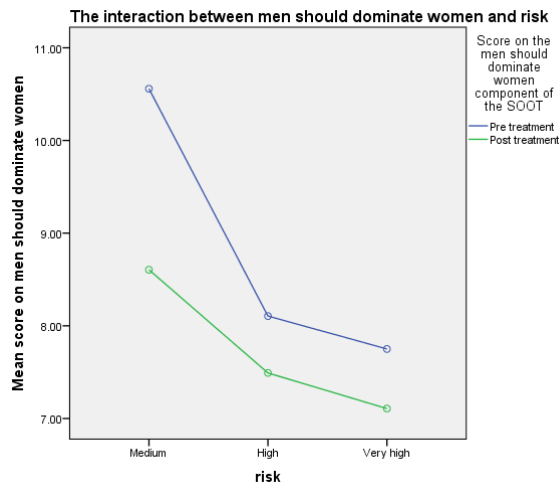
This profile plot illustrates the trend for mean scores on the “child abuse supportive” beliefs component of the SOOT across both the adult offenders and child offenders groups from pre treatment to post treatment. The analysis shows that men who have committed offences against children showed change in the desired direction on the “child abuse supportive” beliefs component of the SOOT, but the scores of men who had committed offences against adults actually increased pre to post treatment. The hypothesis is not supported.

Analysis of the “men should dominate women” component.

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was significant on scores on the “men should dominate women” component $F(2, 125) = 4.98, p < .05$. Thus, there was a significant difference in the scores of the medium risk group ($M = 9.58$) compared to the high risk group ($M = 7.8$) and the very high risk group ($M = 7.43$). There was a significant effect for “men should dominate women” scores pre and post treatment $F(1,125) = 14.25, p < .01$. Scores post treatment ($M = 7.78$) were significantly lower than those pre treatment ($M = 8.85$). The interaction pre and post treatment scores X risk was not significant $F(2,125) = 2.67, p > .05$. Examination of the cell means indicated that although there was a slight decrease in scores on the “men should dominate women” component pre to post treatment in the medium risk group ($M = 10.56$ to $M = 8.61$), high risk group ($M = 8.12$ to $M = 7.49$) and very high risk group ($M = 7.75$ to $M = 7.11$), the interaction between risk and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.41.

Figure 8.41:

The interaction between “men should dominate women” beliefs and risk

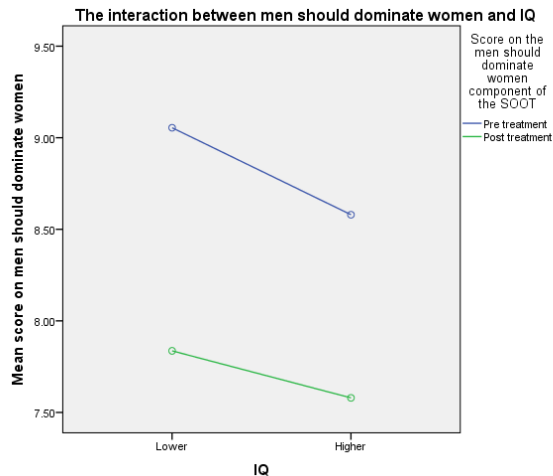


This profile plot illustrates the trend for a decrease in mean scores on the “men should dominate women” component of the SOOT across medium, high and very high categories from pre treatment to post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the “men should dominate women” component of the SOOT irrespective of their risk classification.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the “men should dominate women” component $F(1, 122) = .38, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 8.45$) compared to the higher IQ group ($M = 8.08$). A significant effect for “men should dominate women” scores pre and post treatment was obtained $F(1,122) = 15.5, p < .01$. Scores post treatment ($M = 7.69$) were significantly lower than those pre treatment ($M = 8.79$). The interaction pre and post treatment scores X IQ was not significant $F(1,122) = .15, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the “men should dominate women” component pre to post treatment in the lower IQ group ($M = 9.06$ to $M = 7.84$) and the higher IQ group ($M = 8.58$ to $M = 7.58$), the interaction between IQ and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.42.

Figure 8.42:

The interaction between “men should dominate women” beliefs and IQ



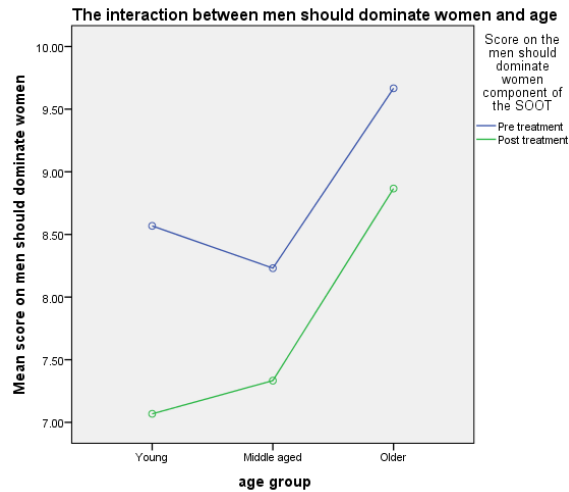
This profile plot illustrates the trend for a decrease in mean scores on the “men should dominate women” component of the SOOT across the lower IQ and higher IQ groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the “men should dominate women” component of the SOOT irrespective of their IQ level.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the “men should dominate women” component $F(2, 125) = 2.85, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 7.82$) compared to the middle age group ($M = 7.78$) and the older age group ($M = 9.27$). A significant effect for “men should dominate women” scores pre and post treatment was obtained $F(1, 125) = 14.84, p < .05$. Scores post treatment ($M = 7.78$) were significantly lower than those pre treatment ($M = 8.85$). The interaction pre and post treatment scores X age was not significant $F(2, 125) = .64, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the women and children cannot be trusted component pre to post treatment in the young age group ($M = 8.57$ to $M = 7.07$), middle age group ($M = 8.23$ to $M = 7.33$)

and older age group ($M = 9.67$ to $M = 8.87$), the interaction between age and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.43.

Figure 8.43:

The interaction between “men should dominate women” beliefs and age



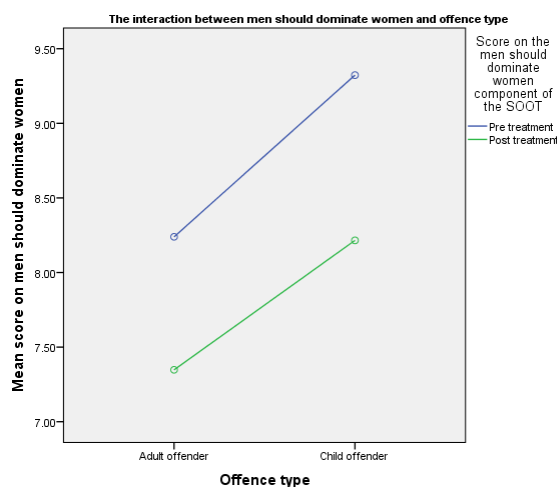
This profile plot illustrates the trend for a decrease in mean scores on the “men should dominate women” component of the SOOT across young, middle and older) age groups from pre treatment to post treatment. There is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the “men should dominate women” component of the SOOT irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the “men should dominate women” component $F(1, 109) = 2.24, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = 8.77$) compared to the adult offenders ($M = 7.79$). A significant effect for “men should dominate women” pre and post treatment were obtained $F(1, 109) = 10.18, p < .05$. Scores post treatment ($M = 7.86$) were significantly lower than those pre treatment ($M = 8.87$). The interaction pre and post treatment scores X offence type was not

significant $F(1,109) = .12, p > .05$. Examination of the cell means indicated that there was a decrease in scores on the “men should dominate women” component pre to post treatment in the adult offender group ($M = 8.24$ to $M = 7.35$), and in the child offender group ($M = 9.33$ to $M = 8.22$). The interaction between offence type and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.44.

Figure 8.44:

The interaction between “men should dominate women” beliefs and offence type



This profile plot illustrates the trend for mean scores on the “men should dominate women” beliefs component of the SOOT across both the adult offenders and child offenders groups from pre treatment to post treatment. The trend is parallel, there is no interaction. Men who have offended against children are more likely to endorse beliefs that “men should dominate women” at both the pre and post treatment stages. The analysis supports the hypothesis that treatment participants show change in the desired direction on the “men should dominate women” component of the SOOT irrespective of whether they have offended against an adult or a child.

8.8.8 The “My Private Interests” Measure: Analysis of treatment change

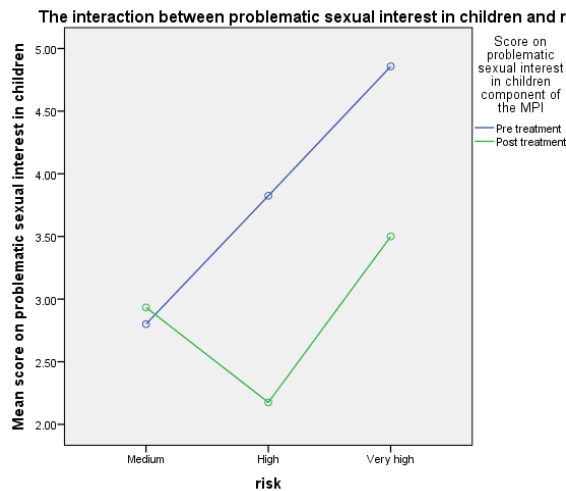
A series of ANOVAs were conducted to explore the relationships between risk, IQ, age of the offender and offence type and pre and post treatment scores on each of the components of the MPI. Mixed between subjects ANOVAs were conducted with pre and post treatment scores on each component as the within subjects variable, and risk/ IQ/ age/ offence type as the between subjects variable. In these analysis, three effects were tested; the effects due to the between subjects variable, the effects due to the within subjects variable, and the interaction between the two factors.

Analysis of the “problematic sexual interests in children” component:

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the “problematic sexual interests in children” component of the MPI, $F(2, 127) = .70, p > .05$. Thus, there was no significant difference in the scores of the medium risk group ($M = 2.87$) compared to the high risk group ($M = 3.0$) and the very high risk group ($M = 4.18$). A significant effect for “problematic sexual interests in children” scores pre and post treatment was obtained $F(1,127) = 5.93, p < .05$. Scores post treatment ($M = 2.72$) were significantly lower than those pre treatment ($M = 3.69$). The interaction pre and post treatment scores X risk was not significant $F(2,127) = 2.31, p > .05$. Examination of the cell means indicated that there was a slight increase in scores on the problematic sexual interest in children component pre to post treatment in the medium risk group ($M = 2.80$ to $M = 2.93$). There was a decrease in mean scores across the other two groups; high risk group ($M = 3.83$ to $M = 2.18$) and very high risk group ($M = 4.86$ to $M = 3.50$). The interaction between risk and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.45.

Figure 8.45:

The interaction between “problematic sexual interests in children” and risk



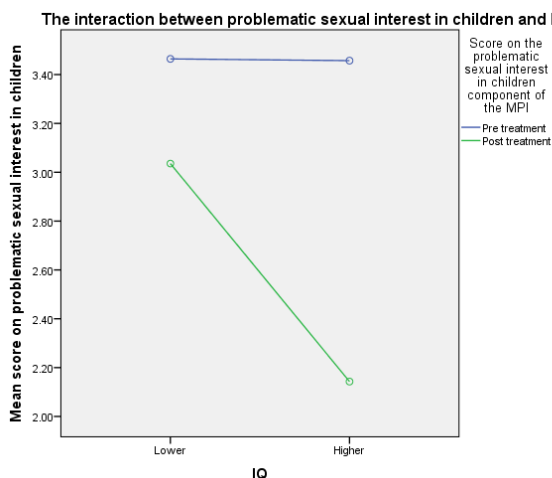
This profile plot illustrates the slight increase in scores on the problematic sexual interests component in the medium risk group pre to post treatment. There is a trend for a decrease in mean scores across the high and very high categories and an overall significant effect pre to post treatment. As such the hypothesis that treatment participants show change in the desired direction on the “problematic sexual interests in children” component of the MPI is supported.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the problematic sexual interest in children component $F(1, 124) = .29, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 3.25$) compared to the higher IQ group ($M = 2.80$). A significant effect for problematic sexual interest in children scores pre and post treatment was obtained $F(1, 124) = 5.17, p < .05$. Scores post treatment ($M = 2.54$) were significantly lower than those pre treatment ($M = 3.46$). The interaction pre and post treatment scores X IQ was not significant $F(1, 124) = 1.33, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the “problematic sexual interests in children” component pre to post treatment in the lower IQ group ($M = 3.46$ to $M = 3.04$) and the higher IQ group ($M = 3.46$ to $M = 2.14$), the interaction

between IQ and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.46.

Figure 8.46:

The interaction between “problematic sexual interests in children” and IQ



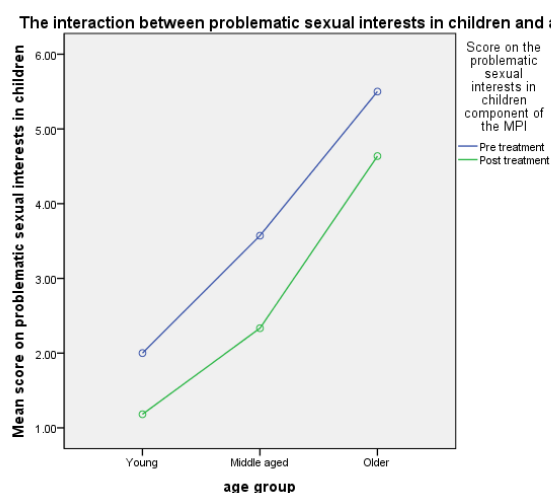
This profile plot illustrates the trend for a decrease in mean scores on the problematic sexual interest in children component of the MPI across the lower IQ and higher IQ groups from pre treatment to post treatment. There is no interaction. Higher IQ men appear to report more shift on this component than lower IQ men. The analysis supports the hypothesis that treatment participants show change in the desired direction on the problematic sexual interest in children component of the MPI irrespective of their IQ level.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was significant on scores on the problematic sexual interest in children component $F(2, 127) = 6.04, p < .05$. Thus, there was a significant difference in the scores of the young age group ($M = 1.59$) compared to the middle age group ($M = 2.95$) and the older age group ($M = 5.07$). A significant effect for problematic sexual interest in children scores pre and post treatment was obtained $F(1, 127) = 6.46, p < .05$. Scores post treatment ($M = 2.72$) were significantly lower than those pre treatment ($M = 3.69$). The interaction pre and post treatment

scores X age was not significant $F(2,127) = .12, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the “problematic sexual interests in children” component pre to post treatment in the young age group ($M = 2.00$ to $M = 1.18$), middle age group ($M = 3.57$ to $M = 2.33$) and older age group ($M = 5.50$ to $M = 4.63$), the interaction between age and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.47.

Figure 8.47:

The interaction between “problematic sexual interests in children” and age

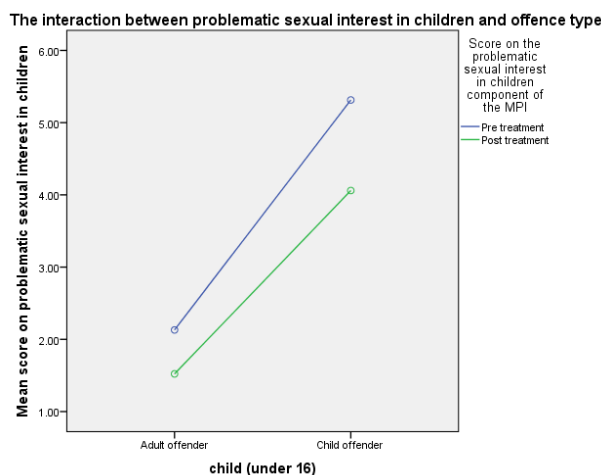


This profile plot illustrates the trend for a decrease in mean scores on the problematic sexual interest in children component of the MPI across young, middle and older age groups from pre treatment to post treatment. The trend confirms that the young age group hold significantly less problematic sexual interest in children distortions than the middle aged and older groups both pre treatment and post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the “problematic sexual interests in children” component of the MPI irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was significant on scores on the problematic sexual interest in children component $F(1, 111) = 8.97, p < .05$. Thus, there was a significant difference in the scores of the child offenders ($M = 4.69$) compared to the adult offenders ($M = 1.82$). A significant effect for problematic sexual interest in children scores pre and post treatment was obtained $F(1, 111) = 4.39, p < .05$. Scores post treatment ($M = 3.03$) were significantly lower than those pre treatment ($M = 4.02$). The interaction pre and post treatment scores X offence type was not significant $F(1, 111) = .53, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the women and children cannot be trusted component pre to post treatment in the child offender group ($M = 5.31$ to $M = 4.06$) and in the adult offender group ($M = 2.13$ to $M = 1.52$), the interaction between offence type and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.48

Figure 8.48:

The interaction between “problematic sexual interests in children” and offence type



This profile plot illustrates the trend for a decrease in mean scores on the problematic sexual interest in children component of the MPI across both the adult offenders and child offenders groups from pre treatment to post treatment. The trend is parallel, there is no interaction. The

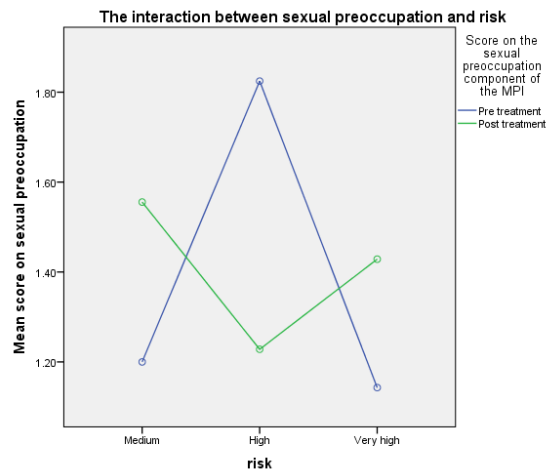
adult offenders hold significantly less problematic sexual interest in children distortions than the child offender group both pre and post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the “problematic sexual interests in children” component of the MPI irrespective of whether they offended against an adult or a child. This result also confirms the validity of the “problematic sexual interests in children” component. We would not expect adult offenders to score highly on this component.

Analysis of the “sexual preoccupation” component:

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the “sexual preoccupation” component of the MPI, $F(2, 127) = .07, p > .05$. The interaction pre and post treatment scores X risk was not significant $F(2, 127) = 1.91, p > .05$. Examination of the cell means indicated that there was a slight increase in scores on the “sexual preoccupation” component pre to post treatment in the medium risk group ($M = 1.20$ to $M = 1.56$) and the very high risk group ($M = 1.14$ to $M = 1.43$) and a decrease in mean scores in the high risk group ($M = 1.83$ to $M = 1.23$). There was no significant difference in the scores of the medium risk group ($M = 1.38$) compared to the high risk group ($M = 1.53$) and the very high risk group ($M = 1.29$). The effect for “sexual preoccupation” scores pre and post treatment was not significant $F(1, 127) = .00, p > .05$. Scores post treatment ($M = 1.38$) were not significantly different to those pre treatment ($M = 1.46$). The interaction between risk and scores on this component was not significant. The interpretation of the interaction is illustrated (figure 8.49).

Figure 8.49:

The interaction between “sexual preoccupation” and risk



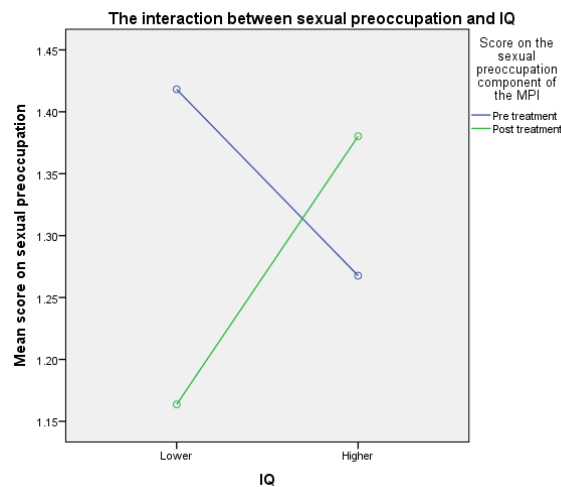
This profile plot illustrates the increase in scores on the “sexual preoccupation” component in the medium and very high risk groups pre to post treatment although overall the effect was non significant. The hypothesis that treatment participants show change in the desired direction on the “sexual preoccupation” component of the MPI, is not supported.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the “sexual preoccupation” component $F(1, 124) = .08, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = 1.27$) compared to the higher IQ group ($M = 1.34$). The effect for “sexual preoccupation” scores pre and post treatment was not significant $F(1, 124) = .08, p > .05$. Scores post treatment ($M = 1.28$) were not significantly different to those pre treatment ($M = 1.33$). The interaction pre and post treatment scores X IQ was not significant $F(1, 124) = .56, p > .05$. Examination of the cell means indicated that there was a decrease in scores on the “sexual preoccupation” component pre to post treatment in the lower IQ group ($M = 1.42$ to $M = 1.16$), and a slight increase in scores on this component in the higher IQ group ($M = 1.27$ to $M = 1.38$). The interaction between IQ and scores

on this component was not significant. The interpretation of the interaction is illustrated in figure 8.50.

Figure 8.50:

The interaction between “sexual preoccupation” and IQ



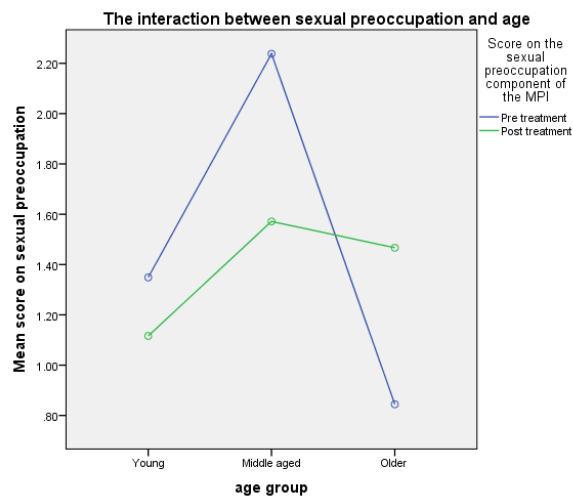
This profile plot illustrates the increase in mean scores for “sexual preoccupation” for the high IQ group and a decrease in mean scores in the lower IQ group from pre treatment to post treatment although the effect was non significant. The analysis does not support the hypothesis that treatment participants show change in the desired direction on the “sexual preoccupation” component of the MPI irrespective of their IQ level.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the “sexual preoccupation” component of the MPI measure $F(2, 127) = .86, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = 1.2$) compared to the middle age group ($M = 1.90$) and the older age group ($M = 1.16$). The effect for “sexual preoccupation” pre and post treatment was not significant $F(1, 127) = .16, p > .05$. Scores post treatment ($M = 1.39$) were not significantly different to those pre treatment ($M = 1.48$). The interaction pre and post treatment scores X age was not significant

$F(2,127) = .265, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the “sexual preoccupation” component pre to post treatment in the young age group ($M = 1.35$ to $M = 1.12$), and the middle age group ($M = 2.24$ to $M = 1.57$), there was an increase in the mean scores in the older age group ($M = .84$ to $M = 1.47$). The interpretation of the interaction is illustrated in figure 8.51.

Figure 8.51:

The interaction between “sexual preoccupation” and age



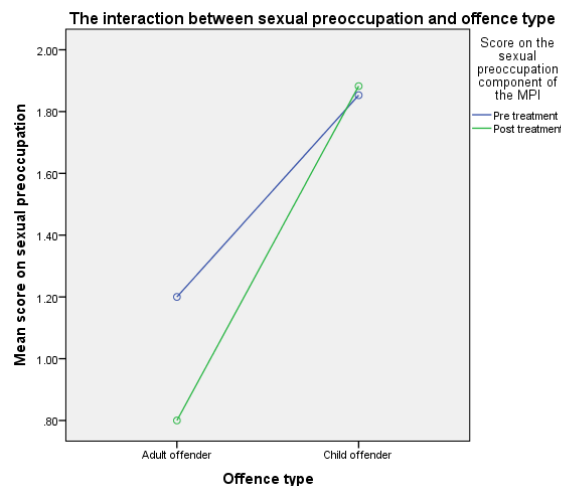
This profile plot illustrates the decrease in mean scores on the “sexual preoccupation” in the young and middle aged groups and the increase in mean scores in the older age group from pre treatment to post treatment although the effect was non significant. This analysis does not support the hypothesis that treatment participants show change in the desired direction on the “sexual preoccupation” component of the MPI irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was significant on scores on the “sexual preoccupation” component of the MPI scale $F(1, 111) = 2.23, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = 1.87$) compared to the adult offenders ($M = 1.00$). The effect

for “sexual preoccupation” scores pre and post treatment was not significant $F(1,111) = .46, p > .05$. Scores post treatment ($M = 1.34$) were not significantly different to those pre treatment ($M = 1.53$). The interaction pre and post treatment scores X offence type was not significant $F(1,111) = .62, p > .05$. Examination of the cell means indicated that although there was a decrease in scores pre to post treatment in the adult offender group ($M = 1.20$ to $M = .80$), the scores in the child offender group did not show much change ($M = 1.85$ to $M = 1.88$). The interpretation of the interaction is illustrated in figure 8.52.

Figure 8.52:

The interaction between “sexual preoccupation” and offence type



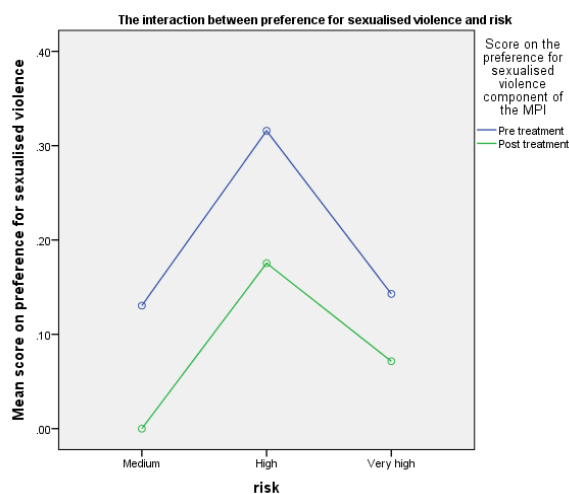
This profile plot illustrates the trend for a decrease in mean scores on the “sexual preoccupation” component of the MPI in the adult offenders group and limited change in the child offenders group from pre treatment to post treatment although the effect was non significant. The analysis does not support the hypothesis that treatment participants show change in the desired direction on the “sexual preoccupation” component of the MPI irrespective of whether they offended against an adult or a child.

Analysis of the “preference for sexualised violence” component:

Risk: A 2 (pre and post treatment scores) x 3 (risk category) mixed model ANOVA revealed that the main effect for risk was not significant on scores on the “preference for sexualised violence” component of the MPI, $F(2, 128) = 1.07, p > .05$. There was no significant difference in the scores of the medium risk group ($M = .07$) compared to the high risk group ($M = .25$) and the very high risk group ($M = .11$). The effect for “preference for sexualised violence” scores pre and post treatment was not significant $F(1, 128) = 3.71, p > .05$. Scores post treatment ($M = .09$) were not significantly different to those pre treatment ($M = .21$). The interaction pre and post treatment scores X risk was not significant $F(2, 128) = .11, p > .05$. Examination of the cell means indicated that there was a decrease in scores on the “preference for sexualised violence” component pre to post treatment in the medium risk group ($M = .13$ to $M = .00$), high risk group ($M = .32$ to $M = .18$) and very high risk group ($M = .14$ to $M = .07$). The interaction between risk and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.53.

Figure 8.53:

The interaction between “preference for sexualised violence” and risk

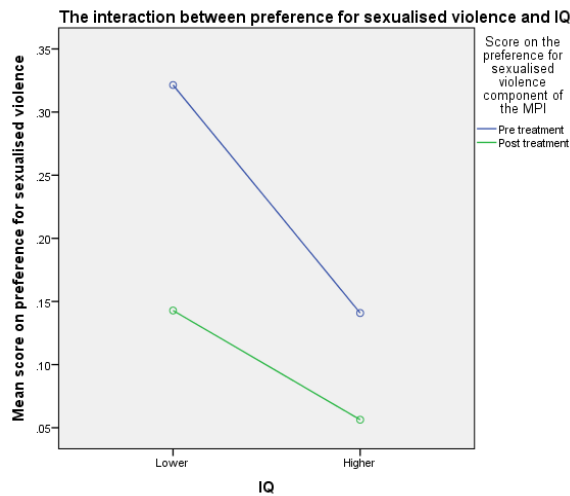


This profile plot illustrates the decrease in scores on the “preference for sexualised violence” component of the MPI in the medium, high and very high risk groups across pre treatment and post treatment although the effect was non significant. Although after treatment participants showed some change in the desired direction on the sexualised violence component of the MPI, the hypothesis that this would be a significant change was not supported.

IQ: The 2 (pre and post treatment scores) x 2 (IQ categories) mixed model ANOVA revealed that the effect for IQ was not significant on scores on the “preference for sexualised violence” component $F(1, 125) = 1.29, p > .05$. Thus, there was no significant difference in the scores of the lower IQ group ($M = .23$) compared to the higher IQ group ($M = .10$). A significant effect for “preference for sexualised violence” pre and post treatment was obtained $F(1, 125) = 5.04, p < .05$. Scores post treatment ($M = .09$) were significantly lower than those pre treatment ($M = .22$). The interaction pre and post treatment scores X IQ was not significant $F(1, 125) = .65, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the “preference for sexualised violence” component pre to post treatment in the lower IQ group ($M = .32$ to $M = .14$) and the higher IQ group ($M = .14$ to $M = .06$), the interaction between IQ and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.54.

Figure 8.54:

The interaction between “preference for sexualised violence” and IQ



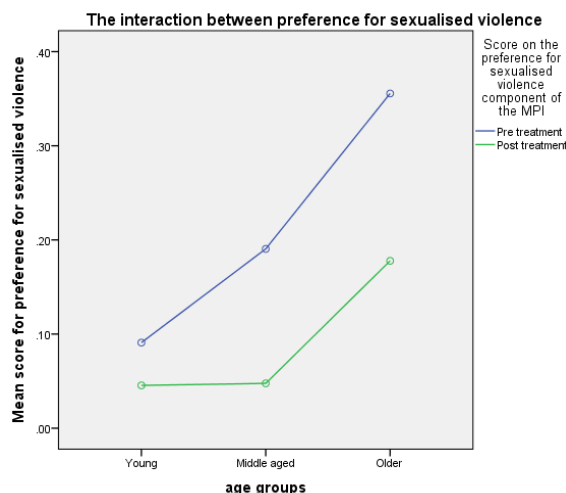
This profile plot illustrates the trend for a decrease in mean scores on the “preference for sexualised violence” component of the MPI across the lower IQ and higher IQ groups from pre treatment to post treatment, there is no interaction. The analysis supports the hypothesis that treatment participants show change in the desired direction on the “preference for sexualised violence” component of the MPI irrespective of their IQ level.

Age: The 2 (pre and post treatment scores) x 3 (age categories) mixed model ANOVA revealed that the effect for age was not significant on scores on the “preference for sexualised violence” component $F(2, 128) = 1.12, p > .05$. Thus, there was no significant difference in the scores of the young age group ($M = .07$) compared to the middle age group ($M = .12$) and the older age group ($M = .27$). A significant effect for “preference for sexualised violence” pre and post treatment was obtained $F(1, 128) = 4.65, p < .05$. Scores post treatment ($M = .09$) were significantly lower than those pre treatment ($M = .21$). The interaction pre and post treatment scores X age was not significant $F(2, 128) = .5, p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the pre to post treatment in the young age group ($M = .09$ to $M = .05$), middle age group ($M = .19$ to $M = .05$) and older age group ($M = .36$ to $M = .18$), the interaction between

age and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.55.

Figure 8.55:

The interaction between “preference for sexualised violence” and age



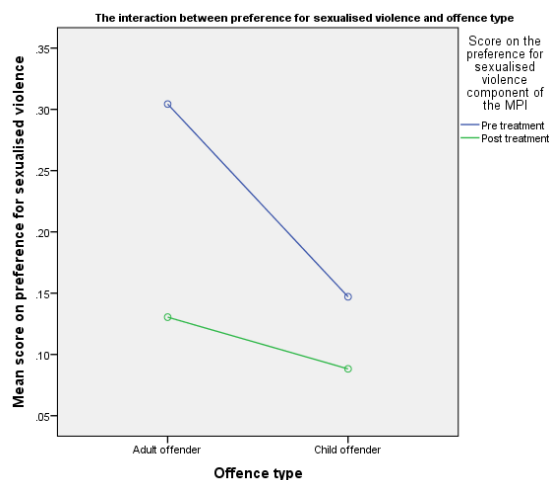
This profile plot illustrates the trend for a decrease in mean scores on the “preference for sexualised violence” component of the MPI across young, middle and older age groups from pre treatment to post treatment. The analysis supports the hypothesis that treatment participants show change in the desired direction on the sexualised violence component of the MPI irrespective of their age.

Offence type: The 2 (pre and post treatment scores) x 2 (offence type) mixed model ANOVA revealed that the effect for offence type was not significant on scores on the “preference for sexualised violence” component $F(1, 112) = .58, p > .05$. Thus, there was no significant difference in the scores of the child offenders ($M = .19$) compared to the adult offenders ($M = .22$). The effect for “preference for sexualised violence” pre and post treatment was not significant $F(1, 112) = 3.59, p > .05$. Scores post treatment ($M = .11$) were not significantly different to those pre treatment ($M = .21$). The interaction pre and post treatment scores X offence type was not significant $F(1, 112) =$

.88, $p > .05$. Examination of the cell means indicated that although there was a decrease in scores on the “preference for sexualised violence” component pre to post treatment in the child offender group ($M = .15$ to $M = .09$) and in the adult offender group ($M = .30$ to $M = .13$), the interaction between offence type and scores on this component was not significant. The interpretation of the interaction is illustrated in figure 8.56.

Figure 8.54:

The interaction between “preference for sexualised violence” and offence type



This profile plot illustrates the non significant trend for a decrease in mean scores on the “preference for sexualised violence” component of the MPI across both the adult offenders and child offenders groups from pre treatment to post treatment. There is no interaction. Treatment participants show change in the desired direction on the sexualised violence component of the MPI irrespective of whether they offended against an adult or a child, but the level of change did not achieve significance and hence the hypothesis is not supported.

8.9 Discussion

This study aimed to determine if participants demonstrate significant change post treatment on measures of criminogenic need. Pre and post treatment scores on all of the measures determined as suitable psychometrically were examined and significant change in the hypothesised direction was observed on the adapted self esteem, impulsivity, ruminations, relationship styles, openness to women, and openness to men measures irrespective of the risk level, IQ, age or offence type of the offender. On both the beliefs that “women and children can not be trusted” and “men should dominate women” components of the SOOT, significant change was achieved in the desired directions for all of the groups tested.

There were however, some results which warrant further discussion. On the “child abuse supportive” beliefs component of the SOOT, no significant pre post treatment change was found. Close inspection of the raw data revealed very low endorsement of the items at both the pre treatment and post treatment stages. The mean scores at both stages were very low, suggesting that the lack of treatment change may be a result of floor effects. In most groups although change in the desired direction was observed, this did not achieve significance.

When examining the scores on the SOOT by risk level, a significant main effect was found on all three components of the SOOT. Visual examination of the profile plots suggests that this main effect is accounted for by the medium risk group whose mean scores are higher at both the pre and post treatment stages across all components. It is not clear why these results have been achieved. When examining the scores on the SOOT by IQ level, a significant main effect on the “women and children can not be trusted” component was found. Visual inspection of the profile plot suggests that this could be accounted for by the lower IQ group who are significantly more likely to endorse these beliefs than the higher IQ group. Again, the reason for this result is not clear. When examining the scores on the SOOT by age, a significant main effect on “child abuse supportive”

beliefs component was found. This was accounted for by the older age group which is mainly comprised of men who had offended against a child. As such, this finding is not unexpected.

In summary, there has been a low endorsement of items on the SOOT at both the pre and post treatment stages. It seems that this has resulted in poor outcomes and led to unexpected findings in relation to risk and IQ level. Further investigation of the SOOT is warranted.

On the MPI measure, significant change in the hypothesised direction was achieved on the “problematic interests in children” component for all participants irrespective of risk, IQ, age or offence type. No significant change was found on the “sexual preoccupation” component. Once again, close examination of the data revealed very low endorsement of items on this component at both the pre and post treatment stages and as such floor effects appear to have impacted the results. One possible explanation for the low levels of reported sexual preoccupation could be the prison environment. Clinically, men often report that their environment is an important factor in levels of sexual interest. Another possible explanation for the lack of change on the “sexual preoccupation” component of the MPI, is the fact that sexual preoccupation requires a different treatment option than CBT alone. Treatment using pharmacological agents is well established and is often the treatment choice for sexual preoccupation with non ID individuals (Bourget and Bradford, 2008). The evidence base for the pharmacological treatment of IDSOs is weak; largely based on case study and poorly controlled trials. The few controlled studies available are of small size concentrating on short term improvements. Despite the methodological shortcomings, several studies suggest that pharmacological treatments can help reduce deviant sexual fantasies and preoccupation whilst treatment is ongoing. As such, it may be that the men for whom sexual preoccupation is a reported problem, may benefit from pharmacological treatment alongside BNM. Although, this type of treatment is available to men within HM Prison Service, the numbers of men who are currently on medication is very small (Lee, personal communication). Furthermore, given the nature of medical confidentiality, it is not known whether or not any of the sample in this study

were using medication to control their sexual preoccupation. It is recommended that this becomes the focus of future research.

Further analyses of the MPI measure revealed a significant main effect for age and offence type on the “problematic sexual interest in children” component, with the older age group and the child offender group scoring significantly higher on this component. The older age band score significantly higher than the middle and young age group at both the pre and post treatment stages. Given the results of the Chi square analysis, we know that there is a significant difference between the age groups and offence type. Younger IDSOs are more likely to have offended against an adult and are, therefore, less likely to endorse items which relate to “problematic sexual interests in children”. Likewise, middle aged and older IDSOs, who are more likely to have offended against a child, would be more likely to endorse items which relate to “problematic sexual interest in children”. This finding adds to the validity of this measure as it appears sensitive to offender types.

Although significant change in the hypothesised direction was achieved on the “preference for sexualised violence” component irrespective of IQ or age, this was not the case for risk and offence type. Once again, close examination of the data revealed low endorsement of items at both the pre and post treatment stages and it seems that floor effects may have impacted the results. The mean scores and profile plot inspection do suggest that scores are impacted in the desired direction as a result of treatment, but clearly not significantly. It seems that in relation to offence type, adult offenders more likely to endorse “preference to sexualised violence” items at both the pre and post stages than child offenders.

In summary, although treatment change was achieved for all groups in relation to “problematic sexual interests in children,” floor effects appear to have impacted the results in relation to the

“sexual preoccupation” and the “preference for sexualised violence” components of the MPI. Further investigation of the MPI is warranted.

There was a significant interaction between openness to women pre and post treatment scores and age. The older age groups scores pre treatment were lower than the young and middle aged group’s scores. Post treatment scores are in a similar range to the other age groups. This result may be accounted for by the larger proportion of child offenders in the older age group who may have had poor opinions of women prior to treatment. Treatment (which is delivered by a therapist team which must include a women), appears to impact positively on the older age group’s opinions of women as their scores post treatment are in line with their younger counterparts.

This study broadly confirms that participants, irrespective of risk level, IQ, age or offence type, change in the desired direction as a result of BNM. On most of the measures significant change has been observed in the hypothesised direction. To what extent can we conclude that the change observed pre to post treatment can be accounted for by the BNM treatment programme? There may be a number of reasons for these changes. This type of research, pre – post treatment design without a comparison group, is unable to provide conclusive information about treatment effect. However, as Harkins and Beech (2007) outline, there are limitations to all research designs, even those which apply scientifically rigorous methodologies. In an ideal world a randomized treatment design or a research study which involved matched comparison groups would be implemented. However, as outlined earlier in chapter 1.7, there are various practical reasons why these approaches are very hard to achieve with this client group in correctional settings. A more rigorous research design would involve the identification of a comparison group. Given that screening for intellectual disability is not routinely undertaken within Prison and Probation Trusts, there is no way of identifying a control group. Further, denying treatment to a sexual offender may have serious consequences and repercussions for both the offender and any potential victims. As yet, NOMS has not been willing to take this risk by adopting this research design.

The pre post methodology adopted in this study, suggests that change in the hypothesised direction has been achieved (in the main) between pre and post treatment. Is there a link between pre to post treatment change and reconviction rates? Are those who do well in treatment less likely to reoffend? It has been argued (Friendship, Falshaw, and Beech, 2003) that it would be useful to compare those deemed as “treated” or “untreated” with recidivism rates. Although there are few studies which have examined psychometric change in sex offender treatment, the results of these studies are generally positive. An early study by Hedderman and Sugg (1996) found that none of a sample of sexual offenders identified as responding to treatment (based on changes on psychometric scales) had been reconvicted of a sexual offence within two years. Beech, Erikson, Friendship and Ditchfield (2001) found that those who had not responded to treatment as measured psychometrically, were more than twice as likely to be reconvicted for a sex offence after six years, in comparison with those who had responded to treatment. Hudson, Wales, Bakker and Ward (2002) found that positive changes on measures of socio-affective problems were associated with decreases in levels of recidivism in a sample of over 200 men who had completed the Kia Marama treatment program in New Zealand. Additionally, Marques, Wiederanders, Day, Nelson and van Ommeren (2005) in their large scale randomized control trial combined post-treatment psychometric scores into a ‘Got it’ scale, which was used to assess how much the participant had met the goals of the programme. A number of psychometrics were included in this scale, including measures of justifications for abuse, deviant sexual arousal, relapse prevention techniques, and responsibility for offending. Individuals who scored highly on the ‘Got it’ scale were found to have been reconvicted at a significantly lower rate than those who had scored poorly. Together these studies provide support for the link between psychometric scores and reconviction outcome and give some hope to the application of the results of this study to preventing future reoffending. However, a recent study, Wakeling, Beech and Freemantle (2011), which examined the relationship between psychometric changes in treatment and recidivism in a sample of 3,773 sex offenders found that there was limited support for the use of the treatment change methodology when

looking at individual psychometrics. As such, the literature is not conclusive. Furthermore, given that all of the previous research has been undertaken with non ID sexual offenders, there is no literature to support a link between psychometric scores and reconviction outcome with IDSOs and this remains an important area for future research.

When developing and evaluating any sex offender treatment approach, ensuring that participants remain in treatment is particularly critical given the relationship of treatment failure to reoffence risk (Hanson and Bussiere, 1998). Hanson and Bussiere found that men who started treatment but failed to complete, were at increased risk of recidivism. As such, the 9 men (7%) who started but did not complete treatment are a concern. In comparing the non completer sample with the sample who did complete treatment, it is clear that there are two main differences. Firstly, non completers tended to be on a fixed sentence, in contrast to the sample who completed treatment who were mainly on indeterminate sentences. This suggests therefore that their incentive to complete treatment was not the same as those who continued. Secondly, three group members had wider psychological/ psychiatric needs (not known prior to treatment starting) which were beyond the remit of the BNM programme. Due to the small sample size within this study, analysis has not been possible, but it is recommended that in the future this becomes the focus of research. In programme evaluation, it is important to consider those that did, and those that did not, complete treatment. Although the relationship between non completion and reoffending has been established with mainstream sexual offenders, this has not been the subject of investigation with IDSOs, and as such it is recommended that this work is undertaken.

It is important however, to note that there are a number of limitations to the study. The first is the fact that the assessment measures used within the study rely on accurate self-report. The value of self-reported data may be somewhat limited in a client group who are known to be highly suggestible and willing to please. Participants who are answering questions may be likely to

respond in a socially desirable manner, particularly if they are aware that the results may feed into their risk reports (Kroner and Weekes, 1996). The transparency of socially appropriate responses in some self-report measures is well documented (Kolton *et al.*, 2001; Vanhouche and Vertommen, 1999). Possible motives for socially desirable responding with sexual offenders include personal embarrassment at disclosing criminality; the need to present 'macho' attributes of self-sufficiency and personal strength; rejecting any personal characteristics that could make them appear capable of committing crimes that they deny; and hope for parole or early release (Kroner and Weekes, 1996). The incentive for parole or early release could result in an increase in socially desirable responding following treatment. It has been suggested that social desirability resulting in floor effects, may have played a role in some of the research findings reported. There was a low endorsement of items relating to offence related attitudes and sexual interests. Although floor effects have previously been reported on attitudinal measures with IDSOs (e.g. Keeling *et al.*, 2006; Newton, Bishop, Ettey and McBrien, 2011), other researchers have not found this (Williams *et al.*, 2007; Lindsay *et al.*, 2007; the SOTEC ID group, 2010). As such, the role of social desirability in this client group is unclear. Further, some of the findings in this study suggest that participants have not been influenced in a socially desirable way. For example, differences between adult and child offenders on the "problematic sexual interests in children" component of the MPI suggest that the respondents have responded honestly. Further research is warranted.

Another limitation of the study is the fact that those administering the assessments were aware that the participants had received treatment, thus enhancing the possibility of interviewer bias. A further problem is that although it is strongly recommended that all assessments are administered by trained BNM staff (and wherever possible the same administrator at both the pre and post treatment stages), in practice this may not always be achievable. As such there may be variability in the way in which the assessments have been undertaken. To overcome such problems future research should use impartial administrators who have been trained in working

with this client group (but were uninvolved in the participant's treatment delivery). It is also important that the inter-rater reliability of each of the assessments is determined.

The lack of a matched comparison group in the research design has already been discussed above. It means that we cannot be certain that the change observed in the self-report measures is due to participation in treatment. It could be for example that change occurs naturally over time, via practice effects, or it could be something else within the prison setting that is causing the changes. Future research should attempt to overcome this problem by utilizing a matched comparison group. This will involve the identification of an ID control group, which will in itself be a difficult task given that intellectual disability is not currently screened for. However, plans for routine screening are in discussion at NOMS, and should this situation change, it is strongly recommended that a more scientifically rigorous treatment outcome evaluation is undertaken.

This study focused exclusively on data obtained from men in custody. The BNM treatment approach is also delivered in the community. Due to administrative problems with data collection, no data from any of the community groups was collated. The view of the community providers is that the missing data tends to be the result of operational issues, such as a lack of resources for data entry, rather than factors that could lead to systemic bias between the custodial and community samples. So although it is hypothesised that the community sample results would not differ significantly from this custody sample, the applicability of the assessment measures to the community participants has not been established. The applicability of these results to the community group must be the focus of future research.

8.10 Conclusions

This study aimed to determine the success of the BNM treatment approach. It was hypothesised that participants' responses on measures of criminogenic need would change in the desired direction post treatment.

Significant change in the hypothesised direction was achieved on most of the measures. IDSOs appear to make changes in the hypothesised direction after BNM treatment irrespective of their risk classification, their IQ level, their age or their offence type. There were however, some areas where no change was observed, notably in relation to child abuse supportive beliefs (a subscale of the SOOT measure) and in reported levels of sexual preoccupation (MPI subscale).

These results provide an important contribution to the literature pertaining to IDSO treatment, and also to those working with ID individuals more generally who will be interested in the applicability of some of the more general criminogenic measures e.g. the adapted self esteem scale, the adapted impulsivity scale, the adapted ruminations scale, and the adapted relationship style questionnaire. There are a number of limitations which mean that we cannot draw too many conclusions from these findings, and it is particularly recommended that future research should explore links between pre post change on the measures and recidivism. It is also recommended that the value of the measures is established with the use of a non treatment comparison group. The results are not conclusive, given that there are limitations with the research design as discussed earlier. We can infer from the outcome study that participants on BNM treatment make changes in the desired direction in relation to their criminogenic needs, but we know little about the processes involved or the experience of treatment. An outcome study cannot on its own provide information about the applicability of the responsivity principle to this client group. As such, a process evaluation was needed to complement the outcome data.

Chapter 9: BNM process evaluation

The research question in this thesis is can the RNR model be successfully applied to the treatment of IDSOs. In order to determine this, an outcome study has been undertaken which has provided information about change on criminogenic needs as a result of treatment. Generally, it appears that IDSOs (irrespective of their risk, IQ, age or offence type) have made positive change as a result of the BNM treatment approach. As such, greater clarity about the applicability of the Risk, Need and Responsivity model to IDSO treatment has been partially achieved. Any treatment evaluation must also consider the views, or experiences, of those involved in treatment. This information is particularly important in relation to the Responsivity principle. The literature pertaining to Responsivity is weak, especially in relation to the treatment of IDSOs. As such, a qualitative research design which examined the experience of treatment from both the participants and the therapists' points of view was designed. In this way, the research design has fully enabled the assessment of the success of the BNM treatment programme in relation to all three principles in the RNR model.

9.1 Aim

The main aim of the process evaluation was to establish participant and therapist views on the factors highlighted in the literature review (chapter 4) as pertaining to treatment Responsivity. More specifically, the objectives were:

- To elicit views about the effectiveness of the BNM treatment approach,
- To elicit views on the group environment,
- To elicit views on the therapist characteristics,
- To elicit views on contextual factors,
- To elicit views on the personal impact of treatment.

9.2 Method

9.3 Design

Geertz (1973) noted that qualitative research aims to provide “rich or thick” descriptive accounts of the phenomenon under investigation, while quantitative research is concerned with identifying occurrences, volumes, or the size of associations between entities. Qualitative analysis can be defined as “being concerned with describing the constituent properties of an entity”, whereas quantitative analysis is concerned with “determining how much of an entity there is” (Smith, 2003).

Qualitative research is guided and directed by those participating in the study. Data are derived from the experiences of the individuals. Thus qualitative researchers are interested in exploring, rather than testing variables (Corbin and Strauss, 2008). Qualitative and quantitative approaches differ in terms of data collection. Quantitative research for example reduces the phenomena to numerical values in order to fulfil statistical criteria and analysis. This data can originate from verbal responses in questionnaires for example but then is transformed using tools such as Likert attitude scales so that quantitative analysis can be carried out. In contrast, qualitative research involves collecting data in the form of naturalistic verbal reports, such as interview transcripts or written accounts. Smith (2003) noted that qualitative data is therefore concerned with interpreting what a piece of text means rather than finding the numerical properties within it. This interpretation is then reported through detailed narrative reports of the participant’s perceptions, understanding and opinions of the phenomenon that is being explored. Smith (2003) stated that this approach is consistent with a theoretical commitment to the importance of language as a fundamental property of human communication, interpretation and understanding given that we live in a society where we make sense of our world and express ourselves linguistically.

Ensuring the Quality of Qualitative Research: Qualitative research is judged in terms of the “trustworthiness” of the observations and the interpretations. Lincoln and Guba (1985) described trustworthiness as the author’s ability to persuade the audience that the research findings are worthy of attention. In quantitative research, trustworthiness is established by providing evidence for the reliability and validity of the data and the researchers’ interpretations. In qualitative research, trustworthiness takes a different form. Lincoln and Guba described four types of trustworthiness.

Credibility is roughly analogous to internal validity. It involves various research activities that make it more likely that credible interpretations and findings will be produced. For example, designing a data collection method that is responsive to the needs of the research participants, including checks of the research process by external peers, and having research participants provide feedback on the findings and interpretations.

Transferability, which is roughly analogous to external validity, is demonstrated by the researcher presenting a description of the time and context in which the study took place. Whether the research aims remain supported at another time in another context is for the reader to determine on the basis of the researchers’ description of the findings and context.

Dependability and confirmability, considered roughly analogous to reliability and objectivity, are demonstrated through a variety of strategies, such as involving others to review the study materials to make sure that the findings are grounded in the data, have sufficient utility, and are not tainted by researcher bias. In qualitative research, the researcher is the primary instrument of the research (Hanley- Maxwell, Al Hano, and Skivington, 2007). Personal and social factors (eg power, communication style, warmth etc) are important to consider throughout the research process.

Two groups of individuals were involved in this research; the treatment participants and the treatment therapists. Taking the treatment participants first, poor literacy skills meant that written forms of data collection are not useful. Interviewing on a one to one basis would have been possible. However, this was the same method which was used in the pre and post treatment assessment process. It was important that the IDSOs did not think that this part of the research had anything to do with the assessment or treatment process. Experience has shown that participants tend to feel empowered and supported by the group dynamic and are more likely to share their opinions in the presence of others who they perceive to be like them in some way (Farquahar and Das 1999). Given that the IDSOs have all shared a common experience of being a participant on BNM, it seemed important to utilise this shared dynamic within the data collection approach. Gathering information about the therapist experiences of treatment could have been obtained via questionnaire or one to one interviewing. A decision was made to adopt the same data collection method across both groups. BNM therapists share a common experience of being a therapist on BNM, and it seemed important to use this shared experience within the data collection approach. Convenience and consideration of the public purse was also considered.

Focus groups have proved to be a useful data collection method in qualitative research (Willig, 2000) and were the preferred data collection method for this study. A focus group is a group interview that uses the interactions between participants as a source of data. Within a focus group the researcher takes on the role of a facilitator whose task is to introduce all of the participants to one another, to introduce the topic of discussion and then gently steer the discussion. The focus group discussions are recorded, and the data is transcribed and analysed, (Wilkinson, 1999). Willig (2000) noted that “steering” could involve periodically recalling the original focus of the group, prompting group members to respond to issues raised by others and identifying agreements and disagreements between participants. In addition, the researcher will also set boundaries to the discussion such as time limits.

Willig (2000) noted that the strength of the focus group is that the researcher can lead participants to respond to one another's opinions and therefore gather rich and detailed data that would not be accessible through one-to-one semi-structured interviews or questionnaires. In addition statements can be extended, challenged and verified which also adds to the strength of the data. Willig also proposed that focus groups create an environment that is less artificial than the one-to-one interview which in turn leads to the generation of data with a higher ecological validity.

Willig further states that focus groups can vary depending on the research question in relation to the make up of the participants. For example, focus groups could be homogenous (where participants share key features) or heterogeneous (where participants are different), pre-existing (groups of colleagues) or new or concerned (where participants have a stake in the subject matter) or naive (where participants do not have any particular commitment in relation to the subject). Wilkinson (1999) considered the advantages and disadvantages of focus groups and proposed that focus groups are useful in gathering opinions but are often voluminous, relatively unstructured and do not lend themselves readily to summary analysis.

Focus groups have proved useful in previous research with people who have intellectual disabilities (Fraser and Fraser 2001). They have been used effectively with people of varying intellectual abilities (Kerr, Cunningham-Burley, and Amos 1997) and specifically with people who have intellectual disabilities (see, for example, Ippoliti, Peppey and Depoy 1994; Barr, McConkey, and McConaghie 2003). Cambridge and McCarthy (2001) noted that focus groups with learning disabled individuals allow for collective observations to surface and for discussion to be built upon and relevant issues or lines of inquiry explored. They also offer important opportunities for including traditionally excluded and marginalised individuals to voice their opinions and participate in research decisions, although indirectly. Cambridge and McCarthy identify four wider opportunities provided by user focus groups; to help people gain confidence in a group

environment; to create safe, non threatening and non intimidating environments for user organisation and discussion; to provide inter member reinforcement, peer support and validation of views and experiences; and to enable member participation in research from which they would otherwise be excluded due to poor literacy skills.

However, several authors have noted that qualitative research with ID individuals presents some methodological difficulties (Sigelman, Budd, Winer, Schoenrock and Martin, 1982; Flynn, 1986; Atkinson, 1988; Biklen and Moseley, 1988). The organisational difficulties of arranging groups for people with learning disabilities are evident from the descriptions of various different group treatment approaches (for example, Cambridge and McCarthy 1997, Keeling, Rose and Beech, 2007). Experience suggests that individuals with more profound learning disabilities, difficulties with expressive and receptive communication and language, complex needs or additional mental health difficulties will be unlikely to participate well or constructively in focus groups. Furthermore, the impact of one or two dominant members can be problematic amongst a group of other individuals who may be suggestible or prone to acquiescence. Further, the group setting provides no anonymity and so participants may be hesitant about expressing contrary or sensitive opinions. These difficulties are likely to impact on the “trustworthiness” of the data as described by Lincoln and Guba (1985) and must therefore be planned and controlled for as part of the research design process.

In order to minimise the potential dangers of working in focus groups with IDSOs and to improve the trustworthiness of the data, attention was paid to the following aspects of data collection; construction of the focus group questions, the group process, and the researcher/facilitator’s role. These aspects of the research are now described.

Construction of the questions: A “topic guide” was developed to ensure the consistency of data collection. “A topic guide can be seen as a mechanism for steering the discussion in a focus group

but not as an exact prescription of coverage” (Arthur and Nazroo, 2003; p115). The guide was developed and structured in line with recommendations by Arthur and Nazroo. More specifically, it was based on the literature reviews outlined in chapters 2 and 3, and the contextual factors which are pertinent to treatment participants and therapists. Two topic guides were developed, one for participants and the other for therapists. Both versions were piloted with three BNM therapists to ensure that they were meaningful. Two of the pilots were conducted in person and the third was undertaken over the telephone. As a result of the pilots, refinements were made. First, it was suggested that in the participant focus group the researcher use symbols/ pictures to aid their recall (participants would be familiar with this approach as it is consistent with the BNM treatment approach). Second, they recommended that the researcher explore in more detail any self assessment of the learning/ changes that they had made as a result of BNM. The topic guides served to provide an aide memoire for the researcher to ensure a standardised approach to addressing key questions of concern to this research in each focus group. As such, items are worded very briefly and not as specific questions. This leaves the researcher free to phrase the questions as he/ she thinks best, based on the flow of information within the focus group (Arthur and Nazroo, 2003).

As has been described previously, eliciting the views of individuals with ID is not as simple as it may seem (Finlay and Lyons, 2002; Flynn, 1986; Flynn and Saleem, 1986). The researcher was mindful of these factors and adapted her style in line with advice in the literature for working with this client group. More specifically, simple open questions to encourage contributions were asked because people with ID tend to acquiesce to closed questions and are generally more suggestible than those without ID (see Clare and Gudjonsson, 1993; Prosser and Bromley, 1989). Language from treatment that the men were familiar with was used. Questions were phrased around terms and concepts that they had learnt about on BNM. Visual prompts were referred to and where appropriate treatment material on the wall in the room was used as part of the discussion.

Symbols from the BNM programme which group members were familiar with were used. Gestures were used to accompany the verbal messages to help refresh memories about treatment concepts and approaches.

A staged questioning approach was used in the groups as is described by Llewellyn (1995). At the start of any interview, it is important to begin with a descriptive open ended question about a general topic; e.g. "What did you like about BNM?" Later, as the researcher – participant relationship strengthens, Llewellyn noted that structural questions help to explore how participants experienced different aspects of their treatment eg: "So, role play seems to have been a useful approach in treatment, tell me how has that helped you?" The third type of questioning suggested is asking contrasting questions. These questions investigate the dimensions of meaning. For example, in one focus group, participants talked a lot about the symbols used in treatment, there was a view that at times standard symbols were valuable and at other times, depending on the context, it was more useful to develop a symbol from scratch. The question asked was "We've talked a lot about symbols to help us remember things. Tell me is it better to use standard symbols, or do you like making up your own symbols?" All three questioning approaches were used within the focus groups.

Focus group process: A broad plan for facilitating each of the participant focus groups was developed. The researcher started by introducing herself and the purpose of the research to group members as part of checking consent to participate and setting the scene. It was explained that the groups had been arranged so that the members could say what they thought about their experience of the BNM treatment programme, what they liked or disliked and why. The researcher explained that this research was taking place to help understand what parts of the programme therapists and participants thought were useful/ not useful. What could be improved and how this might be done. The research would be used to ensure that the BNM programme was the best it could be for other men starting treatment in the future. Ideas from the focus groups and

comments would be written up into a report, but individual comments would not be identifiable to any individual (i.e. names would not be used).

Following this broad introduction and warm up, the researcher started by asking a general question to encourage open discussion. This was followed by more detailed questioning, although if particular issues surfaced spontaneously, then these were addressed at the time. Within the focus groups (participant and therapist), the researcher encountered various group dynamics which needed mediation. For example, group members dominating the discussions, and quieter group members not contributing. It was important to manage contributions respectfully; “Thank you for your thoughts on XX, let’s hear what XX thinks about XX?” Praise was used liberally to encourage and support contributions; “That sounds like you have got a really good understanding,” and “that’s an interesting point, what do others think about that?” It was important to encourage the interactions and shared experiences within the group. Humour was also used to ease anxiety amongst the group. In the participant focus group it was particularly important to pick up on the communication styles of the participants. There was a considerable range of abilities within the group, with some group members verbally eloquent and others little more than monosyllabic. Most participants needed time and space to deliver their view. This range of abilities is expected when working with IDSOs, but requires some skill to manage and enable a useful discussion.

Researcher/ facilitator’s role: The researcher or facilitator’s role within focus groups is pivotal. It is important that s/he has excellent interpersonal skills to manage the research process. Taylor and Bogdan (1984) explain that in order to get access to individuals for research purposes, it is important to project the right image to convince participants that you are non-threatening. Once the researcher has gained access they must continue to use these skills to concentrate on maintaining prolonged contact. They need to continue to project a non-threatening image whilst building up trust. The richest data can be obtained when the relationship between the participant and the researcher is one of trust and rapport, and the latter feels able to express themselves fully

and is able to describe their feelings and views, rather than giving brief, socially-acceptable answers. According to Fetterman (1986), the researcher should be 'courteous polite and respectful' and should avoid uninvited displays of friendliness and familiarity (1991). Therefore, the qualitative researcher needs to be particularly skilful in building and maintaining a research relationship. Taylor and Bogdan (1984) emphasised that they should try to highlight whatever feature they have in common with their respondents, act in an interested way in relation to respondents' views and try to help people wherever possible. Bogdan and Taylor (1982) noted that previous experience with the client group and the research methodology is important. In this study, the researcher is the author of the BNM treatment approach. She is an experienced treatment facilitator with this client group and also provides the staff training for therapists working on the BNM. She is familiar with the prison environment and is at ease both with the treatment therapists and the participants. The close proximity of the researcher to the subject matter under investigation is a potential source of bias which needs to be controlled for. As such, it was important that the researcher acknowledged her potential bias and sought at all times to be open and impartial in her facilitation of the groups.

9.4 Participants

Four treatment sites were selected for this study; 3 custody sites and the only community BNM site. The custody sites were selected on the basis of size of the programme's department, and the level of experience held in delivering the programme. Participants came from four of the nine sites that run BNM in England and Wales, selected to ensure a range of settings (from community to custody, Category "B" and "C" establishments) were represented. These four sites represent the different environments in which BNM is delivered, differing in the length of time the Adapted Sex Offender Treatment Programme (predecessor of the BNM) had been running at that site, (between one year and fourteen years), the number of men treated per year (between 5 and 32), and the size of the BNM treatment team, which varied from three members of staff at one site, to fifteen at

another. This was part of a purposive sampling strategy to gain maximal variation in participants. While maximal variation was sought in both sample groups, it is unlikely that either sample was entirely representative, as those who did not take part may have differed in important ways from those who did. However, as this study takes a qualitative approach, the aim was to capture the unique experiences of the therapists and participants, rather than to strive for complete representativeness.

At two of the sites, the focus groups were recorded via dictaphone. This was agreed by the Governor of each establishment. Research participants consented to having the focus groups recorded. At the other two sites, recording was not possible (dictaphone unavailable/ not working), and so extensive notes with verbatim quotes were taken by the researcher. On average, the therapist focus groups lasted 2 hours, and the treatment participant focus groups lasted on average 1 hour.

Treatment participants focus groups: Nineteen participants attended the four focus groups; 15 men were in custody and 4 in the community. All of the men had been convicted of sexual offences. They had all been assessed as intellectually disabled, that is they had IQs in the range of 60 – 80 and associated adaptive functioning deficits. All custody participants had completed the Becoming New Me treatment programme within the past year. The community participants were currently attending BNM (as this was the first BNM group ever run in the community, it was not possible to include men who had fully completed treatment within the focus group. Furthermore, as sentences usually expire at the end/ soon after treatment finishes, it is difficult to access men in the community once treatment concludes).

Table 9.1:

Demographics of the participant focus groups

Focus group	Age	Sentence type	Sentence length	Offender type	Risk	IQ	Time since treatment finished
Custody site 1	59	Indecent assault	5 years	Child offender	Medium	77	11 months
Category B prison	66	Sexual assault of a child under 13	10 years	Child offender	Medium	80	11 months
Custody site 2	31	Sexual assault of a child under 13	Life	Child offender	Medium	NK	9 months
Category C prison	47	Breach of a restraining order	Life	Adult offender	Medium	62	9 months
	48	Sexual assault of a child under 13	IPP	Child offender	Very High	60	9 months
	36	Sexual assault of a child under 13	IPP	Child offender	Very high	79	4 months
Custody site 3	31	Assault by penetration	Life	Adult offender	Very high	79	3 months
Category B prison	41	Rape	IPP	Child offender	Medium	76	12 months
	33	Sexual assault	IPP	Adult offender	High	72	12 months
	37	Indecent assault on a child	IPP	Child offender	High	65	2 months
	37	Sexual assault	Life	Child offender	Medium	61	2 months
	37	Attempt to commit rape	Life	Adult offender	Medium	65	2 months
	38	Rape	8 years	Child offender	Medium	61	2 months
	33	Causing a child to engage in sex	Life	Child offender	High	65	2 months
Community site	26	Rape	4 years	Adult offender	Medium	69	2 months
	35	Gross indecency	NK	Child offender	NK	72	Current
	44	Indecent assault	NK	Child offender	NK	76	Current
	32	Rape	NK	Adult offender	NK	70	Current
	52	NK	NK	Child offender	NK	NK	Current

* NK = Not known

Therapist focus groups: In total, 20therapists attended the focus groups; 10 women and 10 men. Seventeen therapists worked across three custody sites, and the remaining three were based in the community. Age was recorded in age bands rather than specific age in years and months. The modal age band for the overall sample was 30 - 34 years with approximately half the sample aged under 40 years (55%). There was a difference between the ages of male and female participants with 60% of female participants under the age of 35. All of the male participants were older than 30.

Table 9.2:

Demographics of the therapist focus group

Focus groups	Sex of therapist	Age Band	Staff grade
Custody site 1	Female	55 – 59	Treatment manager
Category B prison	Male	45 – 49	Prison officer
	Male	30 – 34	Trainee psychologist
	Female	30 – 34	Trainee psychologist
	Female	25 – 29	Trainee psychologist
	Male	55 – 59	Prison officer
Custody site 2	Male	55 – 59	Prison officer
Category C prison	Male	40 – 44	Prison officer
	Male	45 – 49	Group worker
	Male	30 – 34	Prison officer
	Male	35 – 39	Prison officer
	Female	20 – 24	Group worker
Custody site 3	Male	30 – 34	Prison officer
Category B prison	Female	25 – 29	Group worker
	Female	45 – 49	Probation officer
	Male	30 – 34	Prison officer
	Female	45 – 49	Treatment manager
Community site	Female	55 – 59	Probation officer
	Female	30 – 34	Probation officer
	Female	25 – 29	Trainee psychologist

All of the therapists were experienced at working with mainstream sexual offenders. All of the therapists (except one) had previously worked on the Adapted Sex Offender Treatment Programme, so the majority of the therapists had extensive previous experience of working with sexual offenders and also with intellectually disabled sexual offenders. The most common staff grade of the therapists was prison officer (45% of the sample). None of the therapists were Chartered or Registered Psychologists.

9.5 Obtaining consent

All of the participants in this research (offenders and staff) were recruited by local coordinators. The local coordinators were members of the treatment team and were therefore familiar members of staff to both the offender and therapist participants. Consent forms were developed in easy read formats accompanied by pictorial images. Issues relating to consent were explained to each

individual in line with the recommendations described in chapter 7.4. Once the local coordinator was satisfied that the research participants had understood the nature of the research and what was required of them, they signed the form. All consent forms were returned to the lead researcher. At the start of each focus group, the researcher checked with all offenders and staff that they understood why they were attending the focus group by inviting thoughts about why they were attending. The researcher checked with all participants that they were still happy to attend the group and ensured that they had completed the appropriate consent form. The participants were offered the opportunity to ask any questions that they might have and they were reminded that they could leave at any time. No one left the focus groups. At the end of the focus group the researcher described how research participants could withdraw from the research if they wanted. All focus group members were given a copy of this in writing. The letter to the offenders was written in a user friendly format; simple language and included visual aids to help understanding. It also included contact details which participants could use if they wanted to complain about the research/ the researcher (No complaints were received).

9.6 Ethical considerations

Before commencement of this research, ethical approvals were obtained from Roehampton University.

One of the cornerstones of research ethics is the concept of informed consent. While there can be challenges in obtaining informed consent from research subjects who do not have an intellectual disability, the inclusion of people with ID presents additional, unique concerns. Determining competence and ensuring that an individual has the cognitive skills necessary for giving fully informed consent is an important consideration in the research process and this has been previously described in chapter 7. Issues relating to consent for the BNM assessment and treatment programme have been previously outlined (see 7.4). The capacity to consent for the participants taking part in this qualitative research study has, therefore, already been determined.

A person with an intellectual disability has the right to receive information that he can understand, and which takes account of his *individual* circumstances, such as level of understanding, reading ability, and knowledge about research requirements. As such, the consent and debrief forms were written to a reading age of 10 years in an easy to read font (Comic Sans) and accompanied by pictorial images (Comic Sans has been found to be a more accessible font for those with learning difficulties, such as dyslexia). Efforts to reduce the cognitive load of the material presented were made. Participant recruitment in sites was undertaken by a local coordinator who had a rapport and previously established relationship with each of the participants. A primary feature of ethics protocols in qualitative research is the quality of the relationship between researcher and participants. The terms of engagement (Walmsley, 2004) need to be negotiated between everyone involved and protocols need to focus on how rapport is established and boundaries maintained. As such, close attention to ensuring that the offender participants were clear about the nature of the research were undertaken. At the start of each focus group with participants, the researcher used her clinical skills to develop rapport with the offenders to enable “supported decision making” approach to decision making (Back and Rock, 1996). The researcher talked through the consent form with the participants to check that all group members understood what they were consenting to prior to the focus group starting. The researcher has some 16 years of experience of working with this client group. As the author of the treatment programme that the men have attended, and national trainer in working with ID sex offenders, she is well versed with the approaches and content of the work they have completed in treatment. The approach adopted was consistent with the ethos of the BNM programme to enable group members to feel supported in making a decision about whether or not to consent to be part of this research.

9.7 Reflexivity considerations

Reflexivity has been defined in a variety of ways by a number of different researchers. The differences in definition largely depend on the philosophical or pragmatic approach adopted. Shaw (2010) concluded that “when the researcher and researched are of the same order, that is, both living, experiencing human beings, it is necessary for us as researchers to reflect on how that might impact the research scenario when gathering data and when afterwards analysing it” (p233). Indeed, issues relating to subjectivity in data collection and interpretation are well documented in qualitative research and must be acknowledged within this research (Bogdan and Biklen, 1982). There are a number of different ways in which the researcher’s role might impact both the data collection and interpretation processes.

As the National Lead for the BNM programme, it could be argued that the researcher has a vested interest in the programme being portrayed as successful. Financial pressures mean that both the researcher and the therapists may want to present the BNM approach in a good light in an attempt to ensure that their jobs are retained. At a time in the organisation when all services are under scrutiny, senior managers need assurance that expensive treatment approaches continue to be a wise investment. The researcher’s approach to the data could be influenced by this knowledge. Further, participants and therapists may want to please the researcher by providing positive accounts of the treatment approach. ID individuals are often described as “eager to please” (Gudjonsson, Hayes and Rowlands, 2000) and the researcher’s role may influence their reporting of the treatment process. For this reason, the researcher was keen to ask participants to discuss both the strengths and weaknesses of the BNM treatment approach.

However, it is also important to acknowledge the strengths that the researcher brought to the research process. As National lead, the researcher was very experienced and skilled at working with both IDSOs and the therapists who complete this work. She designed and wrote the treatment programme, group member and therapist selection processes and implemented

delivery across multiple sites. All of the BNM therapists were personally by the researcher. As such, her skills and experience would have been placed her in a unique position to collect and interpret the data. Qualitative research at every stage depends on the training, insights and capabilities of the researcher. Close involvement of the researcher in treatment evaluation studies has been reported to have a beneficial impact on treatment success or recidivism rates in sexual offenders (Landenberger and Lipsey, 2005).

9.8 Procedure

The researcher contacted the Managers at each site to seek permission for this research to take place. Details about the research aims were provided in writing. Each treatment site was sent a list of possible dates for the focus groups. All focus groups took place between July and October 2010. Treatment Managers were asked to select available therapists and treatment participants to attend the focus groups. Therapists had to either be currently involved in the delivery of the BNM programme or to have recently completed a BNM group. Therapists were selected locally based on availability; i.e. they could be freed up from operational duties to attend the focus group. Treatment participants/ offenders had to be currently involved in or have completed the BNM. At each site, a coordinator was locally recruited to explain the research to all therapists and participants prior to the researcher's arrival at the establishment. The local research coordinators were treatment therapists with whom all research participants were familiar. The researcher briefed each of the local coordinators in relation to the aims of the research and what was expected of each research participant. All research participants were therefore recruited locally by the coordinators who explained the research project and what their participation would involve. The researcher was available as a contact point throughout this process. Local coordinators made arrangements for a suitable room to be available for the focus group discussions. In all sites, a room where BNM treatment takes place was used. This room was therefore familiar to all participants and therapists. The prison treatment rooms were large (easily able to fit 8 – 10

people). In all of the prison sites, the walls of the room were covered with poster work which supported key treatment themes. As such, the surroundings were supportive of some of the discussions within the focus groups. The community site room was smaller, and not specifically designed as a treatment room.

Analysis: If facilitation of the focus groups is successful and it provides a rich data set, this in itself brings a problem. Rich data may be difficult to analyse because it is unstructured. So a careful responsible data analysis method is required.

Smith (2003) explained that there are a number of different approaches within qualitative research methods with overlapping but different theoretical and methodological emphasis. As a result, Smith noted that it is of importance to recognise the different theoretical commitments of the different approaches within qualitative psychology. Given that there is a paucity of previous knowledge in relation to both the experience of therapists and participants in treatment programmes for IDSOs, this research adopted a mainly inductive data driven approach. Thematic Analysis (Braun and Clarke, 2006) was chosen as it is one of the qualitative methodologies that can facilitate an inductive approach, but which also allowed exploration of any ideas that have been previously presented in the literature.

Thematic analysis differs from other analytic methods that seek to describe patterns across qualitative data (e.g. IPA and grounded theory). Both IPA and grounded theory seek patterns in the data, but are theoretically bounded. IPA is attached to a phenomenological epistemology (Smith *et al.*, 1999; Smith and Osborn, 2003), which gives experience primacy (Holloway and Todres, 2003), and is about understanding people's everyday experience of reality in order to gain an understanding of the phenomenon in question (McLeod, 2001). Grounded theory analysis aims to generate a plausible and useful theory of the phenomena that is grounded in the data (McLeod, 2001).

Thematic analysis can offer a more accessible data driven form of analysis than other methodologies which are theoretically driven. In this research, thematic analysis was based on a 'contextualist' perspective, which acknowledges the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'. Therefore, in this study, thematic analysis is used as a method that works both to reflect reality and to unpick or unravel the surface of 'reality'.

Two data sets were the focus of this research: a participant dataset and a therapist dataset. Analysis of the data sets was completed using Thematic Analysis. The phases of analysis were followed as prescribed by Braun and Clarke (2006).

Firstly, the recorded focus group interviews were transcribed verbatim and collated into a table format. The left hand column was used to record the name of the participant and a right hand column was used for comments and coding information. The transcripts were checked against the original audio recordings for accuracy by the researcher. Where no recording of the focus groups was available, the researcher completed extensive notes of the discussions. The researcher then familiarised herself with the full data set by reading the transcripts/ notes several times. With each reading more is gained from the text in terms of understanding the experiences of the participants and becoming responsive to what is being said. Interesting ideas/ comments were noted for later review. Equal attention was given to all ideas. Once an initial list of ideas about the data had been generated, the researcher coded based on features of the data (semantic content). In this way, the data was organised manually into meaningful groups (Tuckett, 2005). The researcher worked systematically through the transcripts/ notes for one focus group first, coding all entries, and then added data from a subsequent focus group to this. This process continued until data from all focus groups had been coded. Extracts of data from transcripts were coded together. Surrounding data was included with data items to provide contextual information as needed. Tensions and

inconsistencies within and across data items were noted and retained so that in some cases, there was supporting and counter evidence for each code. In order to search for themes, relevant coded data extracts were combined to form overarching themes. The essence of each theme was determined and the significance of the themes in relation to each other was explored. Following a review of the themes to make sure that they themes hung together appropriately, a detailed description of each theme and the sub themes was written. Names were given to each theme to provide the reader with a sense of what the theme was about.

Secondly, in order to improve the trustworthiness of the research methodology, two researchers were asked to examine the written materials (transcripts and notes), to check whether the themes and sub themes gave a fair picture of the data. In order to enable this, the transcripts and notes were firstly anonymised (all identifiers were removed from the transcripts and notes). The two researchers worked independently, they did not liaise at any point. They both reviewed all of the written materials and then examined the themes and sub themes that had been developed. Discussions with the researchers were held and any differences were discussed. Most of the differences were semantic, in that different words had been used to describe essentially similar themes and sub themes. Any perceived themes or sub themes which could not be agreed were discarded. As such, all of the themes were verified together with their sub themes by the researcher and two independent researchers.

Finally, the themes and sub themes from this research were also discussed with a group of 14 BNM treatment managers. These treatment managers oversee and supervise BNM treatment across all treatment sites. They are all experienced BNM therapists themselves. Here again, the research themes were considered to be relevant and meaningful. None of the results came as a surprise to them. This suggests that the analysis was undertaken in a meaningful and trustworthy way.

9.9 Results; Step 1

The results are presented in 2 steps. In step 1, the themes from the participant and therapist focus groups are presented. In step 2, an evaluation of the themes in relation to the responsiveness literature (described in chapter 4) is undertaken.

Step 1: The experiences of participants are presented in respect of five master themes in 9.8 and the therapist's experiences are described in respect of five master themes in 9.9. In line with Braun and Clarke's (2006) suggestion that results should be presented at an interpretative level, where relevant, the analysis has been related to the existing literature. To preserve the anonymity of the participants, each focus group member is referred to by a letter. Custody participants were assigned letters A to O. Community participants were assigned letters A to D.

9.10 The experience of treatment from the participant's perspective

The overwhelming participant experience was positive. As one group member suggested; *"I mean we had us laughs, we had us jokes, but we actually got on with us work and that was real hard at times..."* (custody participant)

Five themes were identified from the treatment participants' focus groups about their experience of the BNM treatment programme. The themes and sub themes are summarised in table 9.3 below.

Table 9.3:

Participants experiences of BNM treatment; themes and subthemes

Theme	Subtheme
The treatment process	Specialised treatment approach A process of change
Treatment methods and concepts	Treatment methods Treatment concepts
Feeling positive about the future Feeling supported	Therapist support Support from other treatment participants Respect and safety: "Being treated good."

Stress and pressure	Specific treatment concepts/methods Poor relationships between group members “A bundle of risks” Staff who “haven’t got a clue” Concern about the future
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Each theme and sub theme is explored in greater detail in 9.8.1.

9.10.1 The treatment process theme

All of the participants described how the treatment process had been beneficial to them. Firstly, they valued the specialised treatment approach, and secondly, they recognised a process of change within themselves as a result of treatment.

Sub theme 1: Specialised treatment approach

Some of the participants reported seeing themselves as “different” to others: “*I know that I see things differently to some people. I know that sometimes I don’t do things as good as other people,*” (custody participant C) and; “*there are lots of things I need help with... sometimes I find things harder than other people,*” (custody participant F) and; “*We have to take into the situation everybody’s at different levels, everybody’s got different needs*” (community participant A). It is not clear whether this self identity was experienced as a result of the treatment programme itself, or simply a reflection on how they viewed themselves in relation to others. Their attendance on the BNM, a programme which has been designed exclusively for sexual offenders with ID, was rationalised as: “*Some of us haven’t done much schooling. It never interested me. I don’t read and write that good,*” (custody participant A) and; “*Some people are good at (um) drawing instead of spelling...*” (custody participant E). The BNM was described as a treatment approach for men who have problems with “*reading, writing, dyslexia and pronunciation.*” They described programmes (for non ID offenders) as “*stressful*” with “*too much paperwork,*” suggesting that their view of the BNM was that it was less stressful as there was little paperwork. Many men had previously attended other treatment programmes which had been designed for non ID offenders. They commented that; “*It’s really stressful and embarrassing when they make you do other*

programmes” (custody participant A). They were clear that when attending treatment which had not been adapted to meet their needs, they felt anxious and embarrassed about their disability. Here, in describing their *“stress”* and *“embarrassment”* at having to complete treatment approaches designed for more able offenders, the group members identified feelings of shame and discomfort. Shame has been linked to a lack of progress in treatment. Marshall *et al.*, (2009) suggested that people who experience high levels of shame are likely to be defensive, for example, by denying having done wrong, minimising harm done or blaming someone or something else for their harmful behaviour. They do this in order to reduce their experience of this distressing emotion. As such, it appears that shame is linked to personal distress, denial, motivation and locus of control. This suggests that the experience of shame is likely to be an important factor in predicting an offender’s ability to engage effectively in treatment. Goffman (1961) suggested a relationship between defining a client as intellectually disabled and associated feelings of stigmatisation. Dagnan and Wareing (2004) reported that when stigmatisation is recognised by a person with ID, this may have negative consequences for the individual’s well being. It seems, therefore, that IDSOs experience of attending non ID specific treatment approaches enhances feelings of shame and leads to stigmatisation. These feelings are not apparent when approaches are tailored specifically to meet their needs. It is, therefore, unsurprising that the BNM participants overwhelmingly reported positive experiences of BNM treatment.

Sub theme 2: A process of change

Many men recognised that at the start of treatment, they felt anxious and nervous. They talked about *“bottling up problems”* and not wanting to *“let anyone in.”* Many of them talked about how the treatment process helped them to *“come out of their shell.”* They described the usefulness of pre treatment gelling exercises. All of the participants described treatment as an experience which changed the way they thought about themselves. They likened BNM to a weight being lifted off you: *“We had a box, or like a rucksack, at the back of us, and it was so heavy and*

carrying a lot of problems... all them bits and pieces, we had to empty it and then eventually it does come to a stage where there's nothing in there, the rucksack is lighter" (custody participant A). The men described treatment as a generally positive experience; *"The group was a good experience. It came at a good time for me. I had started being a different person, New Me if you like, when the group started. I was able to carry on working on that and that's been really good. I've still got more work to do"* (custody participant H). The process of change in treatment has been presented elsewhere in the literature. Inevitably, treatment leads to the modification or discarding of one's self-identity. Goffman (1961) suggested that personal change involved developing existing aspects of the self that are socially acceptable, while controlling and suppressing the undesirable aspects. Gove (1985) proposed the internal alteration theory. This is a five step progressive model focused on creating a non offending self. At the start of the model individuals were seen as wholly egocentric and as they moved through the steps they became increasingly concerned for others, they adopted community values and pro-social attitudes, and finally this led to a positive view of the meaning of human existence. Grady and Broderson (2008) described how participants in their study had noted changes in themselves that were not attributable to a specific treatment component. The changes appeared to be more of a result of the therapeutic process as a whole. The authors labelled this as "an internal shift in being" and the essence of this shift in being concurs with the descriptions of treatment reported by the participants in this study.

9.10.2 Treatment methods and concepts theme

When asked about the best bits of treatment some of the participants described positive experiences in relation to both the treatment methods used and the concepts they had learnt.

Sub theme 1: Treatment methods

In describing the BNM experience some of the participants reported that it was “good,” “fun,” “mind blowing” and “hard work.” They liked the way in which the programme was delivered suggesting that it was “about right” in terms of pace, style of delivery and approach. When asked about the best bits of treatment many of the men suggested that the start of the programme was good as it allowed a “gradual build up.” They enjoyed taking part in various pre treatment exercises aimed at developing group cohesion, and recommended that this could be strengthened by encouraging BNM graduates to come to the first treatment session: *“I think that people who have done the programme like before should go in and talk to new people about it.. to help persuade them to do it” (custody participant B)*. They did comment that *“the fun stops at block 7”* which is when participants are asked to give an account of their offending behaviour. They all recognised the need to complete an offence account but acknowledged that this was not an easy thing to do; *“I’ve done a lot of lying in my time and telling the truth to a whole group of people felt really good – like I was doing some good for a change. I had to tell the truth so that I could start to be a better person” (custody participant M)*. This finding is consistent with Hays *et al.*, (2007) who similarly reported that IDSOs found talking about their offending difficult but useful.

Sub theme 2: Treatment concepts

Some of the group members said that the experience of taking on the perspective of other people and seeing the situation from “their shoes” was fundamental; *“You need to put yourself in their shoes and realise what sorts of effects it (offending) can have on people, not just in the short term but also in the long term” (custody participant J)*. Indeed, the ‘New Me tactics’ (6 problem focused coping strategies) were widely considered to be useful: *“A good way for me is to counteract it (Old Me). It’s about... thinking of a better life, or stop and think, or victim empathy. Just using them tactics really. They really really work, you know, they work really well for me” (custody participant I)*. In general, the men felt that it was important to have an opportunity to tell people about their offending; *“I think everyone should know what you’ve done to be in prison. They*

can help you. You can't get help from others unless they know what's going on. We know that New Me needs to be able to talk to people about difficult things – so I think it is important that we practise that in the group. If we didn't tell each other what we'd done it wouldn't be very New Me would it?! It is good to talk and share stuff. It helps the group get cohesive too" (custody participant G). The exercises which were considered to be the most beneficial included 'learning logs' (a diary which encourages group members to generalise their learning from the group room to their day to day life), 'support spiders' (a map of significant pro social people in their life): *"I didn't realise what support I had until I did the support spider work;"* 'New Me strengths' (protective factors) *"We all need support and strengths for the future and you can start working on them whilst you are in here. If you start here then that will help you in the future,"* and skills practice exercises where they role play as New Me: *"When you're in a role play... it feels real, you know this is really important, ... these are areas that could be um sort of risky in the future... it does feel real... it helps you to feel in control.. Old Me would be out of control, but when you're out there (in the role play) you are in control, being and doing New Me"* (custody participant D).

9.10.3 Feeling positive about the future theme

Some of the men expressed positive feelings about the future which suggests positive self-efficacy; *"I feel confident about my future. I've got people who can help me and I am looking for a job"* (community participant B) and; *"When you get out there you can be a better person and if you are a better person you're prospects in life are better.... You keep yourself occupied, not to go down and re offend and go down the same path you went down before"* (custody participant E).

Bandura (1977, 1978) suggests that self-efficacy consists of two aspects; 1) the belief that people have the ability to change, and 2) the belief that change will be beneficial. There is evidence to suggest that self-efficacy is related to treatment outcome. Marshall *et al.*, (2005) found a range of research supporting a relationship between hope and treatment gains for a variety of types of treatment and with a variety of treatment populations. Hope theory suggests that one of the three

crucial components to successful functioning in life, as well as in treatment, is *agentic thinking*, a belief that you are able to achieve your goals, which Marshall *et al.*, (2005) felt was similar to self-efficacy. Marshall and colleagues (2005) argued that clients with beliefs of poor self-efficacy are more likely to feel frustrated or defeated by obstacles to their goals, and will more readily drop out of treatment if they feel discouraged by difficulties, preferring to give up than to continue what is perceived to be a pointless exercise. Individuals who re-offend commonly envisage themselves having “little possibility of change for the better and an impoverished sense of personal agency” (Ward 2002, p. 533). Participants in this study did recognise a sense of personal agency. They talked about their “New Me” as a person who was in control of their life, someone who would not need or want to offend because their life was fulfilled. They described an increased awareness of risk as being an important factor in their future safety: *“Because if you know your risk factors then you’re as New Me you’re keeping them risk factors low aren’t you? And if you keep them low... you stand a good chance of probably not offending anymore hopefully” (custody participant A).*

The use of the word “probably” in the latter part of this sentence suggests some doubt and recognises that Old Me will always be a part of their life. Participants recognised the ongoing need to work on themselves: *“It’s all about practice,”* and *“I’ve found that if you don’t put what you’ve learned to use after doing the course, it’s easy for Old Me to take back over you.”* They talked about the need for continual improvement; *“It’s an ongoing process, it don’t just stop here, you take that out with you in the future and you build on that” (community participant B).* This view is consistent with the view that change is a process through which people can move a number of times before achieving permanent transformation (Cherry, 2005). The quotes illustrate that group members generally reported high levels of agentic thinking, personal agency and feelings of self efficacy. A sense of realism was also seen, showing that participants had an awareness of the likely difficulties they will face in achieving a better life.

9.10.4 Feeling supported theme

The value of support was recognised by most of the group members: *"As you get the support, staff support and the lad's support, and you start to open up, that's when it starts to get easier"* (community participant C). Drapeau et al., (2005) found that offenders easily disengaged with therapy if they did not perceive that they were supported or safe within the treatment process.

Sub theme 1: Therapist support

All of the participants suggested that they were really pleased with the therapists that were assigned to their group describing them as *"excellent," "supportive," "caring" and "understanding."* As one participant said; *"Our facilitators were excellent, understanding and they really listened and gave us support. They were a really great standard. They say to us if you need to talk to us when we're not in class we can see you at any time"* (custody participant H). Grady and Brodersen (2008) similarly reported that all of the participants in their study reported positive comments about their therapists and peers. Indeed, they go on to suggest that the relationships between therapists and participants played a crucial role in motivating participants to make changes in their lives.

Sub theme 2: Support from other treatment participants

Peer support was valued highly; *"The lads on my group were the best. We shared some difficult times, but we also had some good laughs and we all learnt a lot. We are changed men – for the better. I suppose we are New Me!"* (custody participant A). Clearly bonds between the men extended beyond the treatment room per se as many custody participants talked about informal group support sessions on the wings: *"We speak to each other all the time out of the group. Once we became friends on the course, we look out for each other on the wing... The course only happens for a couple of hours each day – there's a lot of other time when you need support. That's the beauty of the group, you've got each other"* (custody participant J). The value of peer support has

been widely recognised in the health literature in relation to maintaining treatment gains (D’Zurilla and Goldfried, 1971; Perri *et al.*, 1984).

Sub theme 3: Respect and safety: “being treated good”

Treatment participants recognised that many felt nervous and anxious at the start of treatment. They stressed the need for a “strong group” to enable group members to “come out of their shell.” Participants used the following phrases to describe the role of support in group; “feeling safe,” “being respected” and “being treated good.” As one participant said; “In my life sometimes people have treated me bad. I’m not blaming that... that’s just the way it is. On the group I was treated good – that felt good” (custody participant B). The experience of respect related to relations they had with therapists and with other participants in group; “Most of my life people have tried to tell me what to do... on this programme, they understood me better” (community participant A).

9.10.5 “Stress and pressure” theme

Some participants also reported experiencing “stress and pressure” on BNM. Participants experienced a number of different stressors;

Sub theme 1: Specific treatment concepts/ methods

The aspects of treatment that were considered to be stressful included the language used to describe risk: “Some of the words...” It was suggested that the way in which the risk factors were presented should be “a bit more easier to understand.” Participants suggested that they found the sex education block to be “childlike” and felt that this block was not necessary for all men.

Sub theme 2: Poor relationships between group members

In one of the groups, participants experienced difficulties between group members which meant the group experience was *“more pressured.”* As one group member said; *“Some days in our group it was too hard to concentrate because there was a few incidents...”* (custody participant A). Other participants reported that there had been issues relating to gossiping out of the group and that this had lead to feelings of mistrust within group members. Issues of trust in treatment are important contributory factors to treatment success. Difficulty in trusting others seems likely to impact on an individual’s ability to form a good therapeutic alliance with treatment staff and on their motivation/ability to be open about things that make them feel vulnerable. McKenzie *et al.*, (2002) reported that a hostile, mistrustful orientation in treatment significantly predicted treatment attrition in a sexual offender treatment programme.

Sub theme 3: “A bundle of risks”

Although group members acknowledged that having to tell others about their offending was difficult they saw this as a one off discreet exercise that they had to get through: *“At first some people found it really difficult in the group and then later when they start to come out of their shells and they want to talk about it... then you can’t shut them up! They want to get it off their chest. It feels good once you get going!”* (custody participant K). The process of telling others was seen to be cathartic. They said that they felt relieved like a *“weight had been lifted off their chest.”* These findings are in line with Hays *et al.*,’s (2007) study of treatment experience with IDSOs. Participants found it harder to sign up and come to terms with the risk factors identified as relating to their sexual offending (known as ‘risky things’ on the BNM); *“I found it hard to accept that these risky things will never go away. It’s ok to talk about the offence – that’s done and you can’t change it. But signing up to the risky things means that you know that’s forever”* (custody participant L). One group member said; *“you need time to work out what it means for you.”* Having to accept that the risk factors which contributed to and drove their sexual offending will always be an issue for them (Old Me), was considered to be *“difficult to come to terms with.”* A group member talked about

being seen as “*a bundle of risks*” which led to negative feelings and self doubt about his ability to have a successful life as New Me.

Sub theme 4: Staff who “haven’t got a clue”

The final stressor experienced by group members related to a lack of understanding from some (non programme) staff; “*Some staff haven’t got a clue They don’t give a toss. That’s hard because they don’t understand*” (custody participant A). More training for staff was recommended; “*I think there should be more staff trained on it... because I think the load on the staff that actually do this work is maybe a little bit too much*” (custody participant C). Some of the men in the community spoke about the need for “*Keyworkers in hostels need to know about the course.*” Custody participants spoke of the need to inform wing mentors⁷ about the programme so that they could help men who are attending treatment. Group members felt that more staff, especially wing staff, needed to know about risk: “*I’m not being funny here but there really should be more people trained up to know about risk*” (custody participant A). A few of the participants talked generally about things they saw or heard on the landings which they recognised as being risk or offending related, but which appeared not to be recognised by non treatment staff. From their description, it seems that group members were identifying offence paralleling⁸ or grooming behaviours amongst other offenders which were being ignored by wing staff. In keeping with Ten Klooster, Dannenberg, Taal, Burger and Rasker’s (2009) study, IDSOs identified that inappropriate staff attitudes, and in this study a lack of knowledge and understanding, were a hindrance to treatment and the promotion of change.

⁷ Offenders who have previously successfully completed treatment and are considered suitable by staff to take on a mentoring role to provide support to those who are currently in treatment.

⁸ Offence paralleling behaviour is best defined as “Any form of offence related behaviour (or fantasized behaviour) pattern that emerges at any point before or after an offence. It does not have to result in an offence; it simply needs to resemble in some significant respect, the sequence of behaviours leading up to the offence” (Jones, 2004; p38).

Sub theme 5: Concern about the future

Participants reported that although they were on the one hand positive about the future, they also had some concerns; *“The course is good, don’t get me wrong, but it don’t go far enough. You go through the programme and you’ve got lots of support. It’s after the programme that you really need the support – that’s when you need your group”* (custody participant M). Another group member said; *“Programmes – they are good. I’ve learnt a lot, but they’s are just part of the puzzle of my future life. There’s so much more help I need. I know in my head that I can keep strong... stop Old Me taking over again, but I also need other basics, like a place to live, a job, a relationship. It’s the whole package that you need... whose gonna help me with them bits?”* (custody participant C). Treatment participants are clearly aware that in order to live a life without reoffending, further support is needed. The research indicates that if released sexual offenders are; provided with stable housing, able to access pro social networks, able to create intimate relationships and find employment, they are less likely to reoffend (Hanson and Harris, 2000; Hanson and Morton-Bourgon, 2005; Hepburn and Griffin, 2004; Willis and Grace, 2008, 2009). Uncertainty and concern about the future lead to feelings of stress; *“You get really stressed out thinking about the out – what’s going to be the rules of the licence conditions... I’m all unsure... we talked about what’s our future going to be like and our future plans and targets... but it needs breaking down... how are you actually going to find a job, what to do first, second...”* (custody participant D) and; *“I am scared about the future – I won’t deny it”* (custody participant C). Being alone was also thought to be a concern about the future and some of the participants suggested that they would like to be able to come to *“a group”* even when treatment was finished.

9.11 The experience of treatment from the therapist’s perspective

Five broad themes about the experiences of BNM treatment from the therapist's perspective were identified in the analysis of the data. The results highlighted the challenging but also rewarding nature of this work which has been previously reported in sex offender treatment (Dean and Barnett, 2010; Wakeling, Webster and Mann, 2005). In describing their experiences with this client group, therapists commonly compared their experience of BNM to their experiences of working with non ID sexual offenders. The themes and sub themes are summarised in table 9.4 below.

Table 9.4:

Therapists experiences of BNM treatment; themes and subthemes

Theme	Subtheme
BNM strengths	Characteristics of ID which are perceived to be beneficial in treatment Personalising treatment Effective concepts, approaches and techniques Strong group cohesion
Therapist satisfaction	"Making a difference" Therapist pride Therapist autonomy
Therapist characteristics	BNM therapist schemata Befriending
Therapist stress	A process of adjustment Group member specific stressors "Boundary dilemma" Feeling that others do not value the work Confusion about treatment concepts Rumination
Coping with stress	Poor therapist relationships "Keeping a distance" "A strong team" Supervision and training

The themes will be discussed in turn, illustrated with quotes from the therapists. Where relevant, interpretation of the results has taken place to relate each theme to the relevant literature. To preserve the anonymity of the therapists, each focus group member is referred to by

a letter. Custody therapists were assigned letters A to Q, Community therapists were assigned letters A to C.

9.11.1 BNM strengths theme

Four areas were described by the therapists as being strengths of the BNM approach.

Sub theme 1: Characteristics of intellectual disability which are perceived to be beneficial in treatment

Treatment staff recognised that this client group are often eager to please and grateful for their opportunity to attend treatment; *“This client group have often had very little in life. We give them a chance to be heard and the opportunity to learn skills to help them improve their lives”* (custody therapist B). In describing the characteristics of group members, many compared ID offenders with non ID offenders. They suggested that BNM group members were *“open”* and *“honest.”* One therapist described the group members as; *“straightforward. They give you the answer without putting any spin on it”* (community therapist C) and; *“I think they’re fairly transparent. You can see if somebody’s at it (malingering) on BNM but you can’t on Core (the treatment approach for non ID sexual offenders), I enjoy it because of that”* (custody therapist D). In comparison, non ID offenders were often felt to be *“blagging it”* in treatment.

Sub theme 2: Personalising treatment

A pattern which was consistent across all focus groups related to the perceived role of the therapist in ensuring treatment success; *“although the work is about them, it’s about what you have to do to help them”* (custody therapist F). Some therapists spoke of the need to personalise the treatment experience for each man in the group. This approach to group treatment is contrary to previous studies on manualised widescale treatment initiatives which reported that interventions tended to depersonalise offenders and treat them as *“others”* (Mair, 2004). In order

to enable an individualised responsive approach, staff see persistence, creative thinking and being flexible as being critical to the change process; *“That’s what you have to do on BNM, keep trying, keep thinking of new ways to get material across” (custody therapist M)*. Some therapists spoke positively about *“having the licence to”* create fun, high energy, active individualised learning experiences. This was contrasted to their work with non ID sexual offenders which was described as *“boring”* in comparison. It seems therefore, that BNM therapists think they are able to balance the needs of each group member whilst delivering a manualised treatment intervention. This is in line with recommendations made in the literature about promoting a balance between “procedural specification” and flexibility, allowing the therapist to use their influence and expertise (Marshall, 2009). Staff clearly recognised that the personalised approach on BNM was different to their experience of facilitating on other non ID treatment programmes, indeed one therapist said; *“On other programmes, they train you up and then just require you to read instructions from a manual” (custody therapist P)*.

Sub theme 3: Effective concepts, approaches and techniques

Many therapists reported success with various specific treatment concepts. Notably, the use of the Old Me/ New Me model which was popular with most therapists. Other treatment exercises which were felt to be effective included; keeping a diary to monitor daily experiences in relation to treatment gains (“Learning logs”), developing a network of support (“Support spiders”), and identifying and developing protective factors (“New Me strengths”). They also liked the introduction of a session structure and suggested that the treatment experience was enhanced through both the increased focus on risk factors, and the positive focus on New Me from the start. Therapists suggested various techniques which in their experience were effective with this client group. The techniques were in line with those recommended by Hurley *et al.*, (1998) for working psychotherapeutically with intellectually disabled clients. Principally, simplification of the concepts and processes used was identified; *“the easier we make it for them then the more likely we are to*

get more quality... back" (custody therapist D). Some therapists recommended breaking the material down and using a *"step by step"* approach. In line with recommendations in the ID literature, therapists also recognised the need for approaches with this client group to be multi dimensional and multi component (Griffiths, Quinsey and Hinsburger, 1989; Courtney, Rose and Mason, 2006). They noted the importance of *"repetition is what you need for it to sink in..."* and advocated that in order to be effective you had to *"Keep dipping your foot in it... keep coming back to it all of the time."* Staff also talked about the need for mutual respect and *"caring for each other"* within the group. These comments suggest that the therapeutic climate in the groups was in line with the recommendations about the importance of therapeutic style in the literature (Beech and Scott Fordham, 1997; Beech, Beckett and Fisher, 1998; Fernandez, 1999; Marshall *et al.*, 2003). The importance of having *"fun in the group"* and creating a *"positive atmosphere"* was recognised. This is in line with Haaven's (2006) recommendations that learning is best achieved when it is engaging and fun.

Sub theme 4: Strong group cohesion

A critical component of a successful group was group cohesion. One therapist summed this up: *"The cohesion with peers is so important in treatment success – it has to be a positive experience for them with others that are also going through the same process"* (custody therapist F). The process of developing a *"strong supportive unit"* was considered to be fundamental to the success of the work. This view is in line with Beech and Scott Fordham's study which (1997) found that successful sex offender groups (defined in terms of in-treatment change) were *"highly cohesive."* Coleman and Haaven (1998) also comment on the need to foster a sense of *"groupness"* and culture among ID clients.

9.11.2 Therapist satisfaction theme

The majority of staff reported high levels of satisfaction in their work on the Becoming New Me programme. The words used to describe the programme included; *“liberating,” “positive,” “future focused,” “responsive,” “personalised,” “effective,”* and *“it gives them hope.”* Many said that they enjoyed the approach and said they used the skills they had learnt in other areas of their work. Satisfaction was linked to three areas: making a difference, pride and autonomy.

Sub theme 1: “Making a difference”

Some therapists reported feelings of satisfaction from their work on BNM; *“I know that I have helped to keep some victims safe through the work I have done” (custody therapist G).* This finding is consistent with Farrenkopf (1992) and Jackson *et al.*, (1997). Therapists reported that this client group are more *“worthy of help”* than other offenders. It can be inferred, therefore, that BNM staff perceive non ID offenders to be less worthy of help. Staff motivation is reinforced during the programme as they are rewarded by *“light turning on moments”* which make the work *“worth it.”* These moments are interpreted as being indicators of treatment success and effectiveness.

Sub theme 2: Therapist pride

Some staff reported experiencing feelings of pride in their work; *“Doing this work gives me a sense of meaning and direction at work. I think we should be very proud of ourselves and the work we do with this client group” (custody therapist D).* Further, some therapists reported that they were *“proud of being part of a world class programme”* and being at the *“leading edge”* of treatment design for this client group; *“I’m proud of the work we do. I know that it is world class and that not many people in the world do this. I am proud to be a part of that. That is my job satisfaction” (custody therapist K.)* This statement is consistent with the findings reported by Freeman-Longo, (1997); Kadambi and Truscott, (2003) and Rich, (1997).

Sub theme 3: Therapist autonomy

Many therapists reported feelings of satisfaction stemming from; *“the fact that you can do different things all of the time, so from a facilitating point of view it’s good fun”* (custody therapist D). They compared their satisfaction with BNM delivery to other non ID treatment approaches. The BNM; *“allows you more freedom to be a good facilitator. We do have a lot of training and skills and I think on the BNM you are given licence to use your skills”* (custody therapist I). Dean and Barnett (2010) reported on an individual treatment approach and found that therapists experienced greater autonomy as a result of their ability to individualise and develop the treatment approach to meet the needs of the client. In this study, therapists generally feel that they are able to use their skills to individualise treatment approaches within a manualised group programme. Some therapists also described how working on BNM had forced them to develop their understanding and reported that this gave them a sense of satisfaction; *“I think it (the BNM approach) helps you as much as it helps them... you have to ... work hard from the start. You can’t sit in the group and hide! You need to really know the material, because you never know when you might need to role play or draw it. It forces you to be on top of the work”* (custody therapist G). Gaining an enhanced understanding of self whilst facilitating treatment was also experienced by Collins and Nee (2010).

9.11.3 Therapist characteristics theme

Staff distinguished themselves from non ID programme therapists in a significant number of ways. This was typified by the statement: *“BNM facilitators are a different breed I think... you’ve got to be a bit different!”* (custody therapist F). Yet, BNM therapists also facilitate on non ID programmes. Many therapists will swap between various treatment approaches. It seems therefore that therapists perceived their role as a BNM therapist differently to their role as a therapist on another non ID programme. The differences appeared to stem from their perceptions and feelings about the client group and their associated behaviours.

Sub theme 1: BNM therapist schemata

In general, therapist perception of their role with this client group was qualitatively different from their perception about working with non ID sexual offenders. One therapist said; *“We kind of accept that they (BNM group members) will probably have a learning thing so that’s okay, and we think how we can best help them, whereas on Core... we become more judgemental of him. There’s something fundamentally different about your attitude as a facilitator, there’s a barrier of blame, there’s a judgement...”* (custody therapist F). Generally, therapists described being less judgemental and less likely to attribute blame when working with ID men. They attributed lack of progress in treatment to the client’s learning difficulty, and not to a lack of motivation or reluctance to be honest in treatment (which was typical of their attitude towards men on non ID programmes). It can be inferred that in general, therapists experience non ID sexual offenders as being more manipulative and devious than BNM men, suggesting that therapists may be more wary and distrusting of non ID sex offenders. The schemata held by BNM therapists about IDSOs and are more likely to lead to supportive treatment behaviours, ie warmth, empathy, and being genuine which have been linked to treatment success.

Sub theme 2: Befriending

In general, the experience of being a BNM therapist was considered to be different to that of a therapist on non ID treatment approaches; *“you’ve almost got to be their best friend... it’s basically palling up.... You need some time for these guys, you need to get closer in some respects to these guys for them to trust you more”* (custody therapist N). Some therapists talked about getting to know the participants which they described as *“befriending.”* They noted that although this was a technique they used to a certain extent with non ID men, it was definitely a part of their work with this client group. They noted; *“Some of the best work we do is outside of the group room. We spend a lot of time with them in their daily lives – that’s where some of the real work goes on”*

(custody therapist A). For some, their role as BNM therapist clearly extended beyond the realms of the treatment room and restraints of the treatment manual.

Sub theme 3: A process of adjustment

Some therapists recognised that there are limitations to their ability to promote change with this high risk and need client group. They described a process of having to adjust to working with this group; *“Once you’ve sort of tailored your expectations and sort of felt comfortable in yourself, knowing what you can achieve and not think you can change the world, then you’re a lot better”* (custody therapist C). Some therapists acknowledged a process of adjustment that they experienced in their transition from working with non ID men to working with ID men. They talked about *“lowering expectations,” “working out what can be achieved,”* and coming to terms with the fact that *“they can not save the world.”* Therapists also described needing to be realistic in evaluating treatment impact and success, acknowledging the extent of the client group’s needs. Appraisal of their efforts was described simply; *“I think we did what we could do...”* In Farrenkopf’s (1992) study therapists reported a progression in trauma in their work with sexual offenders. Four phases were identified; shock, mission, anger, and either erosion or adaptation. The results in this study suggest that a similar process is experienced when working with IDSOs. Firstly, therapists new to the BNM approach describe feeling unsure about what to expect. This can be likened to Farrenkopf’s “shock” phase. In the “mission” phase, therapists talked about needing to work out what can be achieved. Therapists talked about how this can take some time, some suggesting that adapting to working with this client group required exposure to more than one BNM group. They talked about adopting realistic expectations to enable feelings of *“comfort”* in the work. This strategy appeared to be the flip side of what Farrenkopf described as the “erosion” phase. It seems that the adaptive strategies adopted by the therapists in this study, lowering their expectations of what this client group can/ should achieve in treatment, enabled adaptation and promoted feelings of coping with the trauma of this work.

9.11.4 Therapist stress theme

“The pressures placed on you when you are working with this client group are like no other. I’ve worked on many different programmes, and the pressures from this group are the most difficult to cope with” (custody therapist J).

A number of different sources of stress were identified.

Sub theme 1: Group member specific stressors

Some treatment therapists reported experiencing a specific set of stressors relating to the characteristics of intellectual disability which were perceived to make treatment more difficult. They suggested that group members *“got confused”* easily, and often *“struggled”* with concepts before *“just giving up.”* They were described as having a *“low boredom threshold”* and being *“very childlike”* at times. They observed that group members often *“blamed themselves”* for problems unnecessarily, and had a higher incidence of poor coping and in particular self harm. Some therapists described how group members tended to lead; *“very chaotic lifestyles. Their life changes and unstable lifestyles impact on group” (community therapist A).* Within the group *“some (group members) have more needs than others and struggle to keep up with the others.”* As one therapist outlined; *“It’s not just the fact that they are ID, it’s the behavioural problems as well. It’s all there, right in front of you, there is no escaping the behavioural problems which you are working with every day” (custody therapist D).* Some therapists reported that participant’s poor behavioural controls, limited social skills and lack of social etiquette was, at times, distasteful and shocking. One therapist used the word *“repulsive”* to describe group member behaviours. The *“mix”* of group members in a group can also lead to frustration. A *“bad group”* can leave *“battlescars.”* Oftentimes the pressure on treatment places, meant that group composition was largely dictated by external forces; *“We had a lot of IPPs (Indeterminate sentence for Public Protection) at the time that needed to get on treatment. Some come with a judicial review that they needed to get on*

treatment as well. So in some senses, we can be flexible but only within a certain parameter and unfortunately, that combination um, just really put a few nails in the coffin" (custody therapist E).

A few therapists reported that facilitation was less stressful if the group members were similar in terms of their sentence, their levels of need, and evenly balanced in terms of their IQ (mixture of lower functioning and higher functioning within the ID range). Men at the lower end of the IQ range, and those with behavioural problems or mental health problems were cited as being the most challenging.

Sub theme 2: "Boundary dilemma"

Rose, David and Jones (2003) reported that the characteristics of the client group were commonly attributed to stress in care workers. Therapists described how most BNM participants had multiple needs in many domains of their life. Deciding what needs were, or were not relevant, to treatment was seen as stressful and difficult. One therapist said; *"Our group wore us down really with issues that really didn't need to, like they weren't really relevant..." (custody therapist D).* One therapist described this as a *"boundary dilemma."* Recognising that his main role was to provide treatment as is prescribed in the BNM manual, but acknowledging that there were many more things that participants need help with if they are going to live an offence free life. The boundaries of the role as a BNM therapist appeared *"more blurred"* than when therapists were involved with non ID men. The struggle in making sense of the clients' needs, and determining how much involvement to have with them, was described as *"time consuming and draining."* It is clear from these statements that treatment therapists understand that successful change is likely to depend on more than attending a treatment programme alone. They are aware that treatment can help to promote change and start to build strengths, but recognise that wider social and psychological input is needed if desistance is to be achieved. The lack of provision for this client group is seen to be unsatisfactory and leads to feelings of frustration and guilt; *"I think about these a lot more than any other client group I work with... I suppose I feel sorry for them so that's why I kind of think well*

it's not their faultthey really do my head in and I'll get in my own little battle... You question yourself, should I have done more, is it their fault or mine?" (custody therapist G). Many therapists suggested that they felt guilty that they should perhaps have done more to help: *"you can take yourself away and blame yourself..."* This sense of responsibility has been described elsewhere in the literature. Dean and Barnett (2010) reported that therapists often felt overly responsible for the outcome of treatment, feeling that they had let their clients down if progress was not as good as expected.

Sub theme 3: Feeling that others do not value the work

Therapists experienced frustration when they faced challenge from other staff who were perceived as not understanding or valuing their work; *"you've got to cope with the stigma that comes from other people who think the work we do is stupid" (custody therapist O).* A number of different elements to this stressor were noted. One therapist described this position with other staff as *"you are fighting a battle (with non treatment staff) and you feel vulnerable."* This finding is not surprising. Previous studies have reported that society as a whole, and prison officers (who are not involved in sex offender treatment), hold negative attitudes towards sexual offenders (Hogue, 1994). Collins and Nee (2010) reported "an enduring conflict" (p319) between prison officers and treatment therapists. The researcher noted a scepticism which is embedded within prison culture and values, which prioritises security issues over any rehabilitation efforts. Lea, Auburn and Kibblewhite (1999) described a tension for therapists working with sexual offenders. They suggested that they are vulnerable to attracting a "courtesy stigma" through working closely with this client group as they may be perceived by other staff as being sympathetic to sexual offending. Some custody therapists experienced frustration as a result of perceived lack of management support; *"SOTP has been running in jails now for nearly 20 years – why is it that some managers and staff still don't see it as an essential part of the prison regime. Why do we feel like we have to continuously defend the work we do? We need staff to value this work in the same way as other*

roles in jails are valued..." (custody therapist G). Organisational dissatisfaction has been reported elsewhere as correlating with stress in care staff. Rose and Schelewa- Davies (1997) reported that the wider organisational climate and dissatisfaction have been reported to correlate with therapists stress. All of the community therapists described feeling responsible for the men's progress, knowing that in most cases there is no one else able to look out for them; "Their life changes and unstable lifestyles impact on group. They require close monitoring and the nature of the problems and issues they are dealing with, means that facilitators are spending a lot more time (than is normal with non ID men) communicating with others involved in their lives. This is time consuming and draining" (community therapist B).

Sub theme 4: Confusion about treatment concepts: "You can't get away with blagging it"

The upbeat delivery approach of BNM was described by some as causing stress; *"Facilitators find the group draining and stressful. It demands your full attention at all times. It is tiring" (community therapist A). Another source of stress was confusion and lack of clarity around some of the treatment concepts. Some therapists acknowledged that they did not feel confident about certain aspects of delivery. This made them feel uneasy and under pressure as it was widely acknowledged that; "On the BNM there is no where to hide... Having to explain the concepts to the guys in simple terms really means that you have to have a clear understanding yourself... you just can't get away with blagging it!" (custody therapist F). This perceived need to be clear about concepts increased feelings of anxiety if therapists felt unsure about concepts. The treatment concept most commonly cited as difficult to communicate to IDSOs was communicating about risk factors. The number of risk factors, the language used to describe them and the fact that different risk factors applied to different men, was reported to make this concept difficult to explain within a group setting. Given that this is a fundamental part of treatment, it is important that there is clarity around this concept. There was an acknowledgement of transference issues, recognition that therapist lack of confidence would leak into the group room; "I suppose if they can sense that you*

are unsure with it... they are going to read into that aren't they.. so you've got to be quite enthusiastic and lively" (custody therapist A).

Sub theme 5: Rumination

A few of the therapists described how *"working with this client group does impact on home life."* It is clear that the effects of working with this client group and the treatment approach itself, have an impact on therapists. At one level, the needs of the men appears to impact therapists; *"I do find that on occasion I go to bed and I have thoughts going through my head about a group member" (custody therapist G).* Intrusive imagery has been identified in various studies which report on the impact of working with sexual offenders (e.g. Dean and Barnett, 2010; Clarke, 2004; Jackson *et al.*, 1997; Turner, 1993). At another level, the delivery style adopted in treatment appears to be a source of stress; *"You do hear some horrendous things on BNM. Somehow, because we ask them to draw up or to show things, it seems a lot more graphic. Perhaps it is just that these guys are less sophisticated and so they don't gloss over the details – whatever it is sometimes it is hard to deal with and it stays with me" (custody therapist N).* These comments seem to suggest that some BNM therapists have experienced secondary traumatisation (Figley, 1995) in their work.

Sub theme 6: Poor therapist relationships

Where relationships were considered strained or poor between therapists, greater levels of stress were experienced; *"Having to deal with it all (issues brought by the group) and if you are facilitating with X, you're basically facilitating on your own, and that was very, very demanding" (custody therapist J).* Low levels of therapist support have been reported as correlating with increased levels of stress in the literature (Harris and Thompson, 1993; Hatton and Emerson, 1993; Rose, David and Jones, 2003). Therapists felt that this additional stress was *"the final nail in the coffin."* They experienced extreme feelings of frustration and which left them feeling exhausted.

Marshall, Fernandez *et al.*, (2003) reported that clients who are convicted of sex crimes tend to enter into treatment with poor self esteem which makes them sensitive to their therapist's behaviours and characteristics. Again, it is hypothesised that poor co working relationships are likely to leak into treatment delivery and impact the effectiveness of treatment.

9.11.5 Coping with stress theme

Some therapists described various methods for coping with stress which were all problem focused adaptive coping responses. This contrasts to other studies on therapists working with similar client groups who have found higher levels of maladaptive coping responses (eg Hastings and Brown, 2002; Rose, David and Jones, 2003).

Sub theme 1: "Keeping a distance"

Taking some distance from the issues was commonly outlined as a strategy for coping with stress; *"You do need to be able to take some distance from it. Otherwise you would crumble yourself"* (custody therapist F). One therapist summed up the strategies that he used to cope with BNM; *"Retaining focus, keeping a distance, discussing with others."* Other studies have similarly reported strategies for coping which include "personal detachment" (Scheela, 2001).

Sub theme 2: "A strong team"

The importance of working within a close team was described by many: *"It is important to share how you feel and a strong treatment team is really important"* (custody therapist E). The importance of social support has been highlighted previously in the literature. Support from other therapists and from managers has been cited as moderating the impact of stress (eg Stenfert, Kroese and Fleming, 1992; Rose, 1993; Alexander and Hegarty, 2000; Ford and Honnor, 2000). The function of the team appears largely to enable therapists to unwind; *"Part of unwinding and debriefing what you've heard in the session is to share a joke, a funny story. That helps I think to*

allow you to reflect on what happened” (custody therapist A). Another therapist said; *“It’s no secret how stressful it has been ... but we’ve always come out and we have always had a laugh over how bad it has been... we enjoyed it” (custody therapist C).* The need to *“have a laugh...”* about some of the issues relating to group work was described by many. This finding has been previously reported (Scheela, 2001). Story telling was also a method that therapists used to deal with some of the issues relating to this client group. The stories recounted within the focus groups were recited in a humorous way and tended to centre on therapist efforts to improve group member understanding, and also on specific group member problems, for example, recounting examples of poor understanding about sex and body parts.

Sub theme 3: Supervision and training

The importance of supervision was also recognised by all of the therapists. One therapist said; *“It was quite hard but what kept me going was that I ... felt supported by X. I think the supervision and treatment management side of it is really important, you need someone strong” (custody therapist C).* Strong supervisors were seen to be understanding, dedicated, motivating and keen *“to make sure they make life as easy as they can for us.”* One therapist summed up the importance of supervision; *“Supervision is where you can really develop your skills and confidence. Our supervision includes training and skills sharing which is great. Supervision is about development of skills and that’s luckily what we have here. You need confident and quality supervisors – they really need to know the programme well” (custody therapist F).* The importance of supervision has been reported previously (Ellerby, 1998; Dean and Barnett, 2010). The need for ongoing training was recognised as important for all. Therapists valued the opportunity to refresh skills and have extra time to practice role play skills. They spoke about training as a method for improving their confidence about their approach in treatment. They also suggested that being involved as a trainer in national training was helpful to help them maintain their motivation and engagement in the programme.

9.12 Results; Step 2

The results from both the participant and the therapist groups provide new insights into the BNM treatment experience. In order to determine the extent to which the BNM approach had successfully accommodated the responsivity factors identified in the literature, the results above were compared to those previously reported in the literature. This evaluation was undertaken by two researchers. Both were familiar with the responsivity literature and were given a copy of chapter 4 which summarises this research. Both researchers were also given copies of the results as described earlier in this chapter. They were asked to study all the materials and to consider the following;

- The degree to which the responsivity factors identified in the literature were also mentioned in the focus group discussions,
- The degree to which focus group participants and therapists felt that the BNM approach had accommodated these responsivity factors,
- The degree of importance which individuals gave to each responsivity factor, and whether this was for primarily positive or negative reasons.

After their independent analyses, the results were discussed and agreed with the researcher.

9.13 BNM adherence to the general responsivity factors

The general responsivity principle outlines that treatment should be delivered in a way which is responsive to the needs of those participants. The factors identified in the literature are;

- treatment approach (CBT approaches and adapted techniques have proven applicability to successful sex offender treatment),
- group environment (cohesive well led supportive groups have result in individual treatment success),
- therapist characteristics (warm, supportive, empathic therapeutic style is related to treatment success),

- Treatment context (treatment setting, organisational considerations and climate, staff training and support and treatment intensity).

Each factor will be considered in turn.

The treatment approach: In general, the treatment concepts were viewed positively and both therapists and participants reported their usefulness, in particular, the Old Me New Me approach. Participants also described the process of change in treatment as a positive experience which enabled them to feel positive about the future. Therapists also felt that witnessing positive change in group participants contributed to a positive treatment experience. Therapists enjoyed the degree of autonomy that BNM treatment delivery affords them. They valued having the licence to make adaptations to their delivery style to enable personalised learning opportunities. This was considered to be in contrast to other treatment delivery where they felt restrained by the manualised approach. Researchers have previously reported that therapists generally object to the restrictions imposed by a manual, suggesting that they prevent the flexibility that is needed to respond to the unique features of clients (Addis and Krasnow, 2000; Beutler, 1999). This research suggests otherwise. It seems that the approach adopted on the BNM has managed to incorporate both the benefits of a manualised approach and provide the flexibility needed to ensure that the responsivity principle is adhered to. The benefits of manualised treatment delivery has been described by Mann (2009) who concludes that “Treatment manuals need to state what is negotiable and what is not, to allow therapists to inject flexibility into their work while ensuring that they do not abandon the core principles that make a particular intervention effective” (p 129). Clearly, the BNM approach was responsively designed to enable this.

However, the language used to describe risk factors was problematic for both groups. Therapists acknowledged that some concepts, notably understanding and explaining risk to treatment participants, were difficult to put across. Therapist confusion about the nature of risk factors meant that participants were unclear. Some aspects of the programme were described as

difficult to face up to. Talking about offending was also described as a negative experience. Knowing your risk factors was considered to be helpful, but coming to terms with the fact that Old Me would always be a part of your life was difficult to accept. This factor has not been previously described in the literature. The management of this factor is important for BNM. There was also a concern that the sex education block was too childlike and needed revision.

In summary, generally the BNM treatment approach has been developed and delivered in a responsive way. There are some aspects of treatment which must be refined. Notably, the concept of risk and the language used clearly led to negative treatment experiences in both groups. Given that enabling a good understanding of the factors which contributed to risk is a really important part of treatment, it is very worrying. Further, it is recommended that consideration to changes to the sex education block is given. New aspects relating to this factor have been identified in this research. Notably, the negative experience of facing up to the fact that Old Me would always be a part of your life. Accepting that they would always be perceived by others as a “bundle of risks” was difficult. Strategies to manage the negativity are needed in treatment to reinforce feelings of hope. Treatment is unlikely to be successful if it contributes to negative self image and further stigmatisation. There is a need to address this factor within the BNM treatment design.

The group environment: Participants generally described the support they gained from their peer group in positive terms, with bonds established in treatment between participants often extending beyond the group room. Yet, in one group, there were difficulties with one group member which meant that the experience was “more pressured.” Issues relating to trust in the group were also cited as crucial to treatment success. Participants talked about feeling safe whilst in treatment. Therapists also described strong group cohesion within the BNM groups, although poor relationships between therapists can lead to negative treatment experiences.

In general therefore, it is evident that the BNM did adhere to this responsivity factor, although care needs to be taken in relation to group composition to ensure good relationships between group members. Furthermore, therapist relationships also need to be considered when planning treatment delivery.

The therapist characteristics: The researchers noted that the participants described being treated “well” by therapists and treatment staff whilst they were in treatment. All of the participants described admiration for their treatment therapists. They described being treated with respect, which was a change for many. Facilitators were universally described as “understanding” and supportive. Their availability, both in and out of the group, was valued by participants. Many men expressed positive feelings about the future, suggesting that therapists had successfully instilled feelings of hope during treatment. Therapists talked about the pride in their work. They felt that they were “making a difference.” In order to be effective, therapists talked about the fact that they were “a bit different” to other treatment therapists. They described a difference in their approach towards this group which stemmed from a different set of attitudes and thoughts (BNM therapist schemata) and behaviours (befriending). They did recognise however, that they often experienced “boundary dilemmas” when working with this group which can be stressful leading to intrusive thoughts/ rumination. A successful BNM therapist characteristic was considered to be an ability to “keep a distance.”

As described earlier (see chapter 4), the therapists role in treatment is critical. It is evident that from the participant’s point of view this factor has been accommodated for within the BNM treatment design. New aspects to this factor have been identified in this research pertaining to therapist delivery with this client group. That is, the fact that the BNM therapist role is different to that of a non ID treatment therapist. They hold different attitudes (BNM therapist schemata) and are willing to change their behaviour (adopt a befriending role whilst also managing to “keep a distance”). These factors should be considered in relation to therapist selection and training.

Further, given the stress responses described, it is recommended that further research is given to the particular nature of stressors with BNM therapists.

Treatment context issues: Attitudes of staff in the jail who had no involvement in treatment and were considered to not have “a clue” were described as having a negative impact on participants in BNM. Further, participants expressed concern that staff outside the treatment team, were blind to offence related behaviours. They described being aware that some sexual offenders (who were not in treatment) were engaging in behaviours which were aligned to sexual offending. These behaviours were not being identified by the staff as risky or of cause for concern. As such, the focus group members perceive this to be evidence of collusion from these members of staff. This frustration with the perceived collusion of staff with offender behaviour considered to be offence related has not been previously reported in the literature and treatment participants were clear that in order to help sexual offenders refrain from offending, a greater level of understanding about offence related behaviours and the risk factors associated with sexual offending were needed amongst staff generally. Therapists also considered that the lack of support from their peers (who were not involved in treatment) and managers contributed to feelings of stress. Frustration stemmed from a feeling these staff members did not understand or value the work that they did. Therapists did report that their feelings of stress were mitigated by the level of support they received from other treatment staff and in particular their supervisor or treatment manager. Supervision and training opportunities were well regarded.

In this thesis it has been argued that factors which relate to the wider treatment context should be considered as responsivity factors. A strength of the BNM approach is the commitment to supervision and training within the treatment team. As such, the immediate treatment environment appears to provide the necessary support for effective delivery. However, it is clear that there is much room for improvement in relation to the wider organisational context and climate of treatment surrounding BNM delivery. Poor attitudes and support was common place

amongst the wider prison staff and manager group. Further, a new factor has emerged in this research which has not been previously reported in the wider literature. This relates to the frustration experienced by participants observing other offenders engaging in offence related behaviours which are not being challenged by staff. Behaviours which are perceived to be risk related by the IDSOs are not being recognised by non treatment staff due to their lack of understanding about sexual offending. This is of significant concern and requires further attention.

In conclusion, the general responsivity factors which were identified in the literature reviews have also been described as part of the focus group discussions. To a large extent, the accommodations within the BNM approach appear to have contributed to a positive treatment experience for both the treatment participants and the therapists. Nevertheless, there are some areas for improvement and this research has helped to identify where changes are needed to increase the adherence to responsivity. A table summarising these findings is provided at 9.5.

Table 9.5

BNM adherence to the general responsivity principle: a summary of the results

General responsivity factor	Positive experiences		Negative experiences	
	Participants	Therapists	Participants	Therapists
Treatment approach	Specialised treatment approach Process of change Treatment methods Treatment concepts	Personalising treatment Effective concepts approaches and techniques Therapist autonomy	Specific treatment concepts/ methods “A bundle of risks”	Confusion about treatment concepts
Group environment	Support from other treatment participants	Strong group cohesion	Poor relationships between group members	Poor therapist relationships
Therapist characteristics	Respect and safety “being treated good” Therapist support	Pride in the work Making a difference BNM therapist schemata Befriending A process of adjustment Keeping a distance		Boundary dilemmas Rumination
Treatment context		A strong team Supervision and training	Staff who “don’t have a clue”	Feeling that others do not value the work

9.14 BNM adherence to the specific responsivity factors

The principle of specific responsivity ensures that individual differences are accommodated for as part of the treatment process. The factors identified in the treatment outcome literature (see chapter 4) are readiness for change or motivation, level of denial, demographic factors (e.g. age, IQ, and offence type), and interpersonal characteristics for example, anger, hostility, personality disorder, psychopathy and mental health history. The BNM approach was designed with these factors in mind, and a description of the accommodations made is provided in chapter 5. To what extent were these accommodations successful?

There was little mention of the specific responsivity factors described in the literature within the focus group discussions. This is unsurprising, given that these factors were also not described in the process evaluations literature bases reviewed. In this research, participants did talk about a process of change during treatment which they felt worked well for people who they described as needing to “come out of their shell.” It seems therefore that the gradual approach of treatment is useful as a method for increasing motivation and enabling those who are in partial denial to be more open. In one of the groups, both participants and therapists talked about the difficulties that the group had with a group member (who was later transferred out for psychiatric reasons). They described problems with anger and his hostile behaviour which was a cause for concern for the whole group. In another group, group members caught gossiping out of session on the landing were perceived to affect the group environment. Feelings of anxiety and hostility towards the individual led to increased feelings of mistrust within the group.

It appears that although various specific responsivity factors have been noted in BNM treatment, generally the accommodations within the BNM treatment design have been implemented. It is recommended that greater attention to mental health needs is paid throughout

treatment, not just during the selection stage. Further, additional training needs for some therapists have been identified.

This research also identified two additional specific responsivity factors which pertain to this group. These have not previously been described in the literature.

Firstly, a factor relating specifically to ID characteristics. Therapists reported both positive and negative experiences relating to the specific characteristics of intellectual disability when working in treatment. On the one hand, certain characteristics of IDSOs (e.g. honesty, transparency) were considered beneficial to treatment delivery. Yet, on the other, various characteristics (e.g. easily confused, give up quickly, poor behavioural controls) were thought to make treatment difficult. Therapists also described how in relation to non ID offenders, this group were more “worthy of help” which linked to their feelings of pride in relation to being involved in this work.

Second, “view of the future” has been identified as a specific responsivity factor for this group. Some group members talked positive about their hopes for the future and their plans as New Me. Yet, many others talked about a fear for the future; a fear of not being able to rely on the support of the treatment team and peers. Given that most of the participants in treatment had completed BNM some months previously, this fear is could be a consequence of not being a part of a group currently. Indeed, some group members did talk about wanting to continue to be part of a group even though they knew that this was not possible. The participants talked about a fear of being alone and alluded to being afraid that people would not be able to help them with other aspects of their lives that they acknowledged they needed support with (e.g. accommodation etc). Any feelings of worry or fear are likely to impede treatment success as they are likely to impact on feelings of inadequacy and self resilience. This fear for the future has not been reported in the literature although researchers do outline how wraparound support is needed for IDSOs (e.g.

Haaven *et al.*, 1990). Therapists also described concerns about the future for this group. They noted the lack of opportunities available and worried that without support many would struggle to engage successfully in society and manage their lives without reoffending. The management of fear is therefore a responsivity factor which warrants further attention within BNM.

In conclusion, there was little mention of the specific responsivity factors within the focus group discussions. As such, it seems that generally the accommodations within the BNM approach appear to have contributed to a positive treatment experience for both the treatment participants and the therapists. Nevertheless, there are some areas for improvement and this research has helped to identify where changes are needed to increase the adherence to responsivity. A table summarising these findings is provided at 9.6.

Table 9.6

BNM adherence to the specific responsivity principle: a summary of the results

Specific responsivity factor	Positive experiences		Negative experiences	
	Participants	Therapists	Participants	Therapists
Motivation/ denial Individual factors	A process of change		Poor relationships between group members; Not being able to trust others in group (gossiping)	Group member specific stressor; mental health issues
ID specific characteristics	Characteristics of ID which are perceived to be beneficial in treatment; group member openness/ honesty; transparency “worthy of help”			Group member specific stressors: easily confused, low boredom threshold, give up easily, Childlike, self blaming, chaotic lifestyle, lack of behavioural controls, limited social awareness
View of the future	Feeling positive about the future		Concern about the future	Lack of opportunities

9.15 Other specific responsivity factors

A by product of this research has been the knowledge gleaned about other treatment approaches which participants have attended and/ or therapists have worked on. In describing treatment experiences, both participants and therapists often compared their experience on BNM to that on other treatment approaches. Participants talked positively about the BNM approach, liking the fact that it had been specially developed to meet their needs. They acknowledged that their experience of other treatment programmes (developed for non ID offenders) had led to negative treatment experiences, making them feel “anxious” and “embarrassed.” Participants identified feelings of shame and discomfort. Shame has been linked to personal distress, denial, motivation and locus of control. This suggests that the experience of shame is likely to be an important factor in predicting an offender’s ability to engage effectively in treatment (Marshall *et al.*, 2009). As such, shame has been identified as a specific responsivity factor for IDSOs when they attend treatment approaches which have not been specifically designed to meet their needs. Although the identification of this factor is wider than the remit of this thesis, given its likely importance for the treatment of this client group, it has been reported.

Another specific responsivity factor identified by therapists relates to their work with non IDSOs. They described a suspiciousness of this client group. They felt that non ID sexual offenders were more likely to malingering or “blag” their way through treatment. This suspiciousness of non ID sexual offenders appears to link to the previously reported finding that BNM therapists adopt a different set of attitudes, or schemata, when working with ID individuals. This finding warrants further investigation.

9.16 Summary

In this chapter the experiences of BNM treatment have been established in order to provide a greater understanding of the responsivity principle in the treatment of IDSOs. In general, the responsivity factors identified in the literature, and reported in chapter 4, were found to have been adequately managed within the BNM approach. In comparing the results from both participant and therapists, similarities can be seen. As no previous research has reported on the perspective of both therapists and treatment participants, this provides new insights into the responsivity principle in the treatment of IDSOs. A summary of the results in relation to general and specific responsivity is provided.

The general responsivity factors which have been identified are;

- Treatment approach; The specialised treatment approach and effective treatment methods and concepts were described by both stakeholders as contributing to positive treatment experiences. Therapist autonomy to be a “good facilitator” of treatment to enable a process of change in individual participants was also reported positively. Factors which led to negative experiences for both stakeholders included confusion in relation to understanding about risk. Both stakeholders reported that the risk factors related to sexual offending were confusing and complicated. Therapists found the risk factors difficult to explain, and participants reported that they were difficult to understand. Being regarded as a “bundle of risks” contributed to negative experiences for treatment participants. This factor has to date not been reported in the literature.
- Group environment; Both stakeholders reported the value of support from others; notably other therapists and the group itself. Strong group cohesion was considered to be an important factor in enabling positive experiences. Negative experiences resulted from poor relationships between group members or therapists.

- Therapist characteristics; Being treated well by treatment staff contributed to positive experiences. Feeling that you were “making a difference” and having pride in the work was important to therapists. Therapists acknowledged that in their work with IDSOs they adopted a different set of attitudes and behaviour. This is a new finding to the literature and adds to our understanding of the role of the therapist in IDSO treatment. In order to manage feelings of stress, therapists described a process of adjustment and the need to “keep a distance.” Negative experiences in treatment were a result of boundary dilemmas. Ruminating thoughts were a result of stressful experiences.
- Treatment context; Attitudes from those outside of the treatment team were also considered to contribute towards negative experiences for both stakeholders. Therapists experienced stress when non programmes staff were perceived to not value the work that they do, and participants experienced stress when staff were perceived to “not have a clue.” A new responsivity factor relating to poor staff understanding about offence related behaviours was also identified by participants.

The specific responsivity factors which have been identified are;

- Motivation/ denial; the programme was considered to have a gentle build up which contributed to a process of change for the participants
- Individual factors; Both stakeholders recognised that unstable mental health needs were a factor in treatment. Where this was an issue in groups it resulted in poor relationships between group members. Not being able to trust others due to fear that details had been gossiped about out of the group was another factor.

- ID specific characteristics; This is a new specific responsivity factor. It pertains to the various characteristics of intellectual disability which were perceived by therapists to either enable effective treatment delivery, or make delivery more difficult.
- View of the future; This is another new specific responsivity factor. Both stakeholders reported concerns/ fears about the future for IDSOs. This related to a lack of opportunities for this group. Although some men were indeed positive about the future, others shared their concerns.

As a by product of this research, some new responsivity factors pertaining to the treatment of this group in other contexts has been provided. Notably, shame is described as a specific responsivity factor experienced by IDSOs when required to complete treatment which has not been adapted specifically to meet their needs. When working with non IDSOs, therapists report a suspiciousness of this client group which they do not report when working with IDSOs. This finding speaks to the attitudinal shift described earlier in relation to therapist characteristics. Taken together, the research findings add strength to some of the previously reported findings and add new insights into new factors which warrant attention in treatment design.

9.17 Limitations of the research

This study has identified some useful insights into the responsivity factors which are important in the treatment of IDSOs. However, there are a number of limitations which impact on the trustworthiness of the results and as such it is suggested that the findings should be interpreted with caution. The main limitations are described below.

Subjective reporting of treatment experiences: This study was based on subjective reports about treatment experiences using qualitative methodology. There is, therefore, a possibility that the experiences of those taking part in this sample may not be generalisable to others engaging in

treatment work in these settings. Furthermore, it is not possible to determine to what extent the apparently valuable or problematic features are due to generic characteristics of the treatment model, or to more specific features of these groups and their context (for example, the particular personal qualities of the group therapists or treatment participants).

Although the topic guide outlined the main themes for discussion in the focus groups, the development of the discussion around the themes was left open for the group. If during discussion there was no mention of a responsivity factor, it was concluded that the focus group participants had not experienced this factor as problematic or valuable. The conclusion was that it had been accommodated for within the programme design and, as such, was perceived to be irrelevant. If, on the other hand, a responsivity factor was discussed and considered to be appropriately managed within the programme, it was regarded as an example of success; an example of adherence to the responsivity principle. If a factor was identified and considered to have not been appropriately managed, then this was noted as a lack of adherence to the responsivity principle as there was obviously a need for improvement. It is possible that there are alternative explanations. Focus group participants may have been unwilling or scared to talk openly. Although this is a concern, it is thought to be unlikely given that the discussions generally lasted for an hour and that in many groups there was mention of personal material, suggesting that the group participants felt safe and comfortable within the focus groups. Nevertheless, the methodology adopted must be considered when interpreting these results.

Given that the majority of the participants and therapists were custody based, the balance of feedback from the community was not equally balanced. Although the treatment experience in the community did align with the themes described in this research, there was one specific difference which is worthy of further exploration. All of therapists talked about the difficulties associated

with dealing with the “chaotic” lifestyles of this client group, but the impact of this was more pronounced for the community providers. Clearly, IDSOs in custodial settings are contained within a structured environment where most decisions are made for them. In the community, there is less structure and/ or containment. Community facilitators struggled to cope with both the quantity of the presenting issues and the nature of these problems. Poorly made decisions, difficulties coping with change, lack of social awareness, poor financial management and other general day to day living skills meant that facilitators often spent their own time out of group helping participants and this had an impact on their experience of this work. Although community facilitators recognised that this was not part of their role as treatment therapist, they acknowledged that they felt they wanted to help, this led to “boundary dilemmas” which were identified in this research. It is recommended that further research is conducted to explore the differences between community and custody delivery of the BNM approach.

Within this study, therapists described BNM specific attitudes and behaviours which meant that they considered their role in treatment with ID sexual offenders to be different to their work with non ID sexual offenders. The sub themes within this theme were labelled therapist schemata, befriending and a process of adjustment. Further research is recommended to explore attitudes towards this client group to determine if those who volunteer to work with this client group are different in some way to those who work only with non ID sexual offenders.

Small sample sizes: The themes described above were taken from a series of focus groups. However, some different categories did emerge in the analysis, and while there appear to be strong similarities between the groups, there may also be some important differences between the experiences of the men undergoing treatment in custody and their community counterparts. The small numbers of men in the community sample especially mean that results should be interpreted

with caution. Future research into the differences between the treatment experiences in community and custody would be of interest.

Biased samples: The views of the men in the focus groups may represent a biased sample. Local coordinators invited the men to the groups. Those who were perceived to be negative about treatment may have been selected out at this stage. Further, they may have self selected out by refusing to attend the focus groups. Their views were therefore not represented within this study.

Desire to please: It is possible that the participant's positive comments about their experiences in treatment reflected their desire to please the researcher. It is important to acknowledge that the researcher is the Clinical Lead of this treatment approach for this client group. This may well have influenced the group members' responses. However, group members' ability to talk about negative aspects of the group suggest that any interpersonal influence of this kind may have been comparatively mild. There were few (if any) negative comments made about treatment therapists and although this may reflect the warmth the group members felt towards the therapists, it may also reflect a reluctance to talk openly to someone who they knew was part of NOMS. It would be interesting to replicate this study using an independent researcher.

Reliability: The reliability of the information gleaned from the programme participants could also be a possible limitation of this study. As has been described earlier in this chapter, a number of studies have been reported which show that people with ID are likely to exhibit memory problems, incomprehension, anxiety, recency effects and acquiescence which undermine the validity of their self reports (e.g. Balla and Zigler, 1979). Various strategies to minimise the potential impact of these characteristics were employed in this research to improve the reliability. The focus group technique allowed the researcher to respond flexibly to meet group need, and this was particularly helpful within the focus groups. Questions were phrased simply and probes in the

form of visual symbols from the treatment programme were used to provide clarity. These were specifically chosen from the treatment programme to guarantee familiarity. Researchers have demonstrated that people with ID can provide valid and meaningful self reports when researchers have taken care about how material is presented (Voelker, Shore, Brown-More, Hill, Miller and Perry, 1990; Chapman and Oakes, 1995, Mattison and Pistrang, 2000; MacDonald, Sinason and Hollins, 2003).

It is important to consider the impact of the questioning process within the focus groups. Hugman (1991) in his work with ID clients, suggested that service providers typically control the interests of service users through the interaction of language and social relationships. A number of studies have highlighted how interactions between those with ID and therapists members are often asymmetrical (e.g. Prior *et al.*, 1979; Cullen *et al.*, 1983; Antaki *et al.*, 2002). Antaki *et al.*, (2002) found that care staff adopted a series of non neutral practices in interviews. Staff were observed offering evaluative feedback on interview responses, suggesting advice on the basis of interviewees' answers, rejecting potentially valid answers, suggesting more elaborate accounts to the interviewee than they had offered themselves and reworking their responses. Staff controlled the interaction through the use of particular types of questions, through nomination of speakers and through reformulation of the resident's utterances. It was suggested that these deviations could have occurred as a result of the interviewer intending to treat the ID client supportively and therefore be more inclined to acknowledge their general duty of care. Antaki and Rapley (1996) provided extracts from assessment interviews between clinical psychologists and people with ID and showed how, through the adoption of non neutral practices to pursue a perceived correct response from the service user, the interviewer is "shepherded" into producing "pseudo-acquiescent" responses. These non neutral practices occur through reformulating service user

responses, shepherding them to a response which conforms to the interviewer's guess or stereotype of the interviewer's beliefs (p216), and treating service user responses as irrelevant.

Antaki, Finlay and Walton (2007) noted the danger of disempowerment. They described a standing dilemma for any members of staff working with this client group in relation to the process of interaction. Staff direct the interaction towards certain statements, signal when a resident's utterance is a source of trouble, and lead the residents to producing particular types of statements. Identities of the residents as incompetent and dependent, and staff as knowledgeable and in charge are acted out in the details of the interaction.

Although the researcher attempted to facilitate the focus groups in a fair, open and respectful way, it is possible that she inadvertently "shepherded" group member responses in a way which was influenced by her preconceived ideas about treatment experiences. Future research would be valuable in this area.

9.18 Conclusion

This chapter describes a process evaluation which was designed to capture information about the BNM treatment experience for both treatment participants and treatment therapists. In this chapter the experiences of treatment have been established in order to provide a greater understanding of the responsivity principle in the treatment of IDSOs. This has included the identification of factors which influence the treatment experience for therapists as well as group participants. Any negative experiences on therapists are likely to impact on their therapeutic style and thereby affect treatment success. To date, there are no reported studies on the experience of therapists working with IDSOs, and only one study which reported on the IDSO participant's experience in treatment. As such, this research adds to the existing knowledge base. The use of qualitative methods has provided a rich data source from which we are able to make stronger

conclusions about the role of both general and specific responsivity in BNM treatment. Further, some new insights into factors which affect responsivity for treatment with IDSOs (and with non IDSOs more generally) have been described.

Chapter 10: Overview, Discussion and Conclusions

10.1 Introduction

Intellectually disabled offenders are likely to constitute approximately 30% of the offender population (Motttram, 2007). Yet, there is little research available to guide the assessment or treatment of this client group. The thesis aimed to advance our understanding of the assessment and treatment of intellectually disabled sexual offenders (IDSOs).

10.2 Overview of the thesis and rationale for the research undertaken

Chapter one of this thesis outlines the rationale for this research. A review of the literature indicated that the best validated offender rehabilitation model was the Risk, Needs and Responsivity (RNR) model (Andrews *et al.*, 1990). Meta analytic studies have shown the 3 principles of the RNR model to apply to various groups, including sexual offenders. However, no work to date has looked at the relevance of the model to IDSOs. As such, the research question for this thesis is; can the RNR model be successfully applied to the treatment of IDSOs?

In chapter two, the Risk principle is outlined in more detail and a review of the literature pertaining to IDSOs is provided. As far as the first principle of Risk is concerned, researchers agree that treatment should be targeted at higher risk offenders. Moreover, it has been shown that over treatment of sexual offenders can lead to higher rates of recidivism (Marshall and Yates, 2005) and should, therefore, be avoided.

Chapter three focuses on the second principle, Need. Offenders have many needs, of which only some are related to their offending. These are referred to as their criminogenic needs. Other needs may be apparent, but they may have no causal relationship to the offending behaviour.

Criminogenic needs should serve as the targets for any treatment intervention (Mann, Hanson and Thornton, 2010). Treatment success can be defined as change in the desired direction in level of criminogenic needs (Harkins and Beech, 2007). Assessment of criminogenic need is undertaken using psychometric measures, yet the literature review showed that there are very few psychometric assessments available to assess the criminogenic needs of IDSOs. Measures which have been developed for non IDSOs are too complicated for use with this group (Lindsay, 2002).

Chapter four addressed the third principle, Responsivity. Widely acknowledged as the principle which has received the least research attention, the literature provided little clarity in relation to the treatment of IDSOs. The responsivity principle is concerned with the methods and processes of treatment and its ability to enable learning within its participants. It has two aspects; general and specific responsivity. General responsivity covers the factors which are relevant to the treatment approach, and as such, they concern external factors which might impact on treatment success for the whole target group. Specific responsivity refers to factors which are specific to the individual in treatment. There is very little detail in the literature about general or specific responsivity factors pertaining to IDSOs. In order to discover these factors, firstly, a review of the treatment outcome literature pertaining to sex offenders, and where available IDSOs, was undertaken. Second, a review of the literature pertaining to the treatment experience of participants in treatment was undertaken.

Four general responsivity factors were identified. Firstly, the treatment approach. The literature showed that the most successful treatment approach with sexual offenders is cognitive behavioural treatment. However, the evidence to support the use of this approach with IDSOs is less clear. The emphasis on cognitive factors might pose problems for IDSOs unless the techniques are specifically adapted for this group. Second, group environment and process issues have

warranted some research attention, but again, the literature has not been specific to IDSOs. The treatment context is the third general responsivity factor. Treatment setting, organisational considerations, staff training and support, and treatment intensity have been shown to have an impact on treatment success. The final general responsivity factor relates to the importance of the therapist in treatment. Therapist characteristics, notably their style and approach to treatment, have been highlighted as important variables for both sex offenders and IDSOs. As this factor was considered to be important for the target group, a further literature review focusing on the point of view of the treatment therapist was carried out. This yielded a mixed picture. Therapists working with sexual offenders generally identified a mixture of positive and negative treatment experiences, whereas those who worked with ID individuals reported only negative treatment experiences.

Finally, a review of the literature concerning the specific responsivity factors which could influence treatment outcome was undertaken. This highlighted four factors; motivation in treatment, denial, demographics (e.g. age, gender, ethnicity, IQ, and offence type) and various individual factors (e.g. psychopathy, anger and so forth).

In chapter 5, the development of the Becoming New Me treatment programme is described. The BNM was designed to meet the principles of RNR. It was recognised as successfully meeting the standards of best practice by an independent panel of experts (the CSAP). Details relating to the practicalities of treatment provision and the attempts to control for standardised delivery are also described within this chapter.

Chapter 6 provides a brief introduction to the research. The research question was; can the RNR model be successfully applied to the treatment of IDSOs? In order to answer this question, 3 studies were undertaken.

The first study is outlined in chapter 7. A battery of assessment measures was developed to assess the criminogenic needs of IDSOs for the BNM programme. These measures were either developed specifically for this purpose or adapted from existing measures. As such, there is a need to establish the psychometric properties of each measure. In this study, the internal reliability and construct validity of each measure were established. The eight assessments in the BNM battery were; the adapted self esteem questionnaire, the adapted impulsivity scale, the adapted ruminations scale, the adapted relationships style questionnaire, the adapted openness to women scale, the adapted openness to men scale, the Sex Offender Opinions Test (SOOT) and the My Private Interests (MPI) measure. The participants in this study were all 140 IDSOs who started BNM treatment between July 2009 and April 2011 in custody. 131 completed the programme (and the pre and post treatment assessments). All of the assessment measures were found to have reasonable psychometric properties as determined by internal consistency and principal components analyses. As such, the use of the BNM assessment battery is supported. There was one subscale, the paraphillic interests of the MPI which had a very low response rate. It seems that the respondents in this sample reported few paraphillic sexual interests, especially post treatment. As such, a decision was made not to undertake any further analyses on this subscale.

Chapter 8 outlines the outcome study which aimed to determine change on levels of criminogenic need as a result of BNM treatment. For programmes to be effective, the treatment approach must target the needs of all of the participants it aims to cater for. IDSOs are a diverse group who have a wide variety of characteristics and associated needs. Can a single treatment programme address the needs of this diverse population? It was hypothesised that all BNM participants would achieve positive change in treatment irrespective of their risk level, IQ, age or offence type. A sample of 131 treatment completers was used (same sample as outlined in chapter 7). Significant pre to post treatment change in the expected direction was observed on the

adapted self esteem, impulsivity, ruminations, relationship styles, openness to women, and openness to men measures irrespective of the risk level, IQ, age or offence type of the offender. On two of the subtests of the SOOT (“women and children can not be trusted” and “men should dominate women”), significant change was achieved in the expected directions for all of the groups tested. However, on the “child abuse supportive” beliefs component, no significant change was reported. Floor effects created difficulties in assessing change on this component. On the MPI measure, significant change in the hypothesised direction was achieved on the “problematic interests in children” component for all participants irrespective of risk, IQ, age or offence type. Similarly significant change in the expected direction was also achieved on the “preference for sexualised violence” component irrespective of risk level, IQ or age. Although there was change in the expected direction for both adult and child offenders, the level of change did not achieve significance. No significant change was reported on the “sexual preoccupation” component, once again, floor effects created difficulties in assessing change. It is recommended that the SOOT and the MPI are investigated further in future research.

In summary, this study broadly confirms that the adapted assessment measures are sensitive to treatment change irrespective of risk level, IQ, age or offence type. On most of the measures change has been observed in the expected direction and it can be concluded that the adapted assessment are useful in their assessment of IDSOs for treatment purposes.

Whilst it is, of course, important that treatment is found to have met its goals, it is also important to examine why participants may drop out, or fail to complete treatment. Ensuring that participants remain in treatment is particularly critical given the relationship of treatment failure to reoffence risk (Hanson and Bussiere, 1998). During the period of study, nine men (7%) started BNM treatment, but failed to complete. This rate of 7% is lower than reported in many other studies of

non completers in sex offender treatment. A review of the non completer cases revealed some differences between this group and the group who completed treatment. Principally, the difference related to type and length of sentence. The majority (77%) of the non completers were on fixed sentences, whereas the majority of the completers (64.1%) were indeterminate sentences (IPPS or Life Sentences). Successful completion of an offending behaviour treatment approach like BNM, is often considered as evidence of addressing risk, and is therefore, helpful in contributing towards decision making in relation to progressive moves through the prison system and eventual release for men on indeterminate sentences. Men on fixed sentences do not have to prove a reduction in risk. Further, 4 of the 9 non completers had relatively short sentences, less than 4 years. Once again this is in contrast to the sample who completed treatment, where 81% had a sentence length of over 4 years.

Chapter 9 reports on a qualitative study which aimed to examine the treatment experience of BNM participants and therapists. In order to evaluate how well the BNM approach accommodated the general and specific responsivity factors outlined in the literature, eight focus group discussions were held (four with BNM participants and four with BNM therapists). In total 19 participants and 20 therapists across 4 BNM treatment sites (3 in custody and 1 in the community) took part. The results were analysed using Thematic Analysis (Braun and Clarke, 2006). Two researchers independently reviewed the literature summary and focus group results to determine whether the BNM approach had successfully accommodated the responsivity factors which had been identified in the literature review.

The literature outlines 3 general responsivity factors; treatment approach, therapist characteristics and treatment context. In general, the treatment approach was viewed positively by both participants and therapists. Both groups also recognised that the treatment approach

enabled a process of change which was described as contributing to positive feelings about BNM. There are some aspects of treatment which must be refined. Notably, the concept of risk and the language used clearly led to negative treatment experiences in both groups. Given that enabling a good understanding of the factors which contributed to risk is an important part of treatment, this warrants further attention. Further, it is recommended that consideration to changes to the sex education block is given. New aspects relating to this factor have been identified in this research. Notably, the negative experience of facing up to the fact that Old Me would always be a part of your life. Accepting that they would always be perceived by others as a “bundle of risks” was difficult. Strategies to manage the negativity are needed in treatment to reinforce feelings of hope. Treatment is unlikely to be successful if it contributes to negative self image and further stigmatisation. There is a need to address this factor within the BNM treatment design. Therapists enjoyed the degree of autonomy that BNM treatment delivery affords them, and contrasted this to other treatment delivery where they described feeling restrained by the manualised approach. Given that the BNM approach is manualised this finding was surprising. It appears that the style of the manual and the training approach was seen by therapists as enabling facilitators to deliver BNM in a responsive way. Clearly, the design of the BNM has enabled this.

Participants generally described the group environment and support they gained from their peer group in positive terms, with bonds established in treatment between participants often extending beyond the group room. Yet, in one group, there were difficulties with one group member which meant that the experience was “more pressured.” Issues relating to trust in the group were also cited as crucial to treatment success. Participants talked about feeling safe whilst in treatment. Therapists also described strong group cohesion within the BNM groups, although poor relationships between therapists can lead to negative treatment experiences. In general, the BNM did adhere to this responsivity factor, although care needs to be taken in relation to group

composition to ensure good relationships between group members. Furthermore, therapist relationships also need to be considered when planning treatment delivery.

The participants described being treated “well” by therapists and treatment staff whilst they were in treatment. All of the participants described admiration for their treatment therapists. Their availability, both in and out of the group, was valued by participants. Many men expressed positive feelings about the future, suggesting that therapists had successfully instilled feelings of hope during treatment. It is evident that from the participant’s point of view this factor has been accommodated for within the BNM treatment design. Therapists talked about the pride in their work. They felt that they were “making a difference.” New aspects to this factor have been identified in this research pertaining to therapist delivery with this client group. That is, the fact that the BNM therapist role is different to that of a non ID treatment therapist. They hold different attitudes (BNM therapist schemata) and are willing to change their behaviour (adopt a befriending role whilst also managing to “keep a distance”). These factors should be considered in relation to therapist selection and training. Further, given the stress responses described, it is recommended that further research is given to the particular nature of stressors with BNM therapists.

Finally, a number of responsivity factors were identified in relation to treatment context. Staff who were not involved in treatment were described by participants as not having “a clue.” This included other prison and probation staff and hostel workers. This relates to the frustration experienced by participants observing other offenders (not in treatment) engage in offence related behaviours which were not being challenged by staff. Behaviours which were perceived to be risk related by the IDSOs were not being recognised by staff due to their lack of understanding about sexual offending. Treatment participants were clear that in order to help sexual offenders refrain from offending, a greater level of understanding about offence related behaviours and the risk

factors associated with sexual offending were needed amongst staff generally. This responsivity factor is of significant concern and requires further attention. Therapists also considered that the lack of support from their peers (who were not involved in treatment) and managers contributed to feelings of stress. It is clear that there is much room for improvement in relation to the wider organisational context and climate of treatment surrounding BNM delivery. Therapists did report that their feelings of stress were mitigated by the level of support they received from other treatment staff and in particular their supervisor or treatment manager. Supervision and training opportunities were well regarded. As such, the immediate treatment environment appears to provide the necessary support for effective delivery, but the support and culture within the organisation more widely warrants further attention.

There was little mention of the four specific responsivity factors described in the literature within the focus group discussions. As such, it appears that generally the accommodations within the BNM treatment design have been successfully implemented. It is recommended that greater attention to mental health needs is paid throughout treatment, not just during the selection stage. This research also identified two new specific responsivity factors. Firstly, a factor relating specifically to ID characteristics. Therapists reported both positive and negative experiences relating to the specific characteristics of intellectual disability when working in treatment. On the one hand, certain characteristics of IDSOs (e.g. honesty, transparency) were considered beneficial to treatment delivery. Yet, on the other, various characteristics (e.g. easily confused, give up quickly, poor behavioural controls) were thought to make treatment difficult. Therapists also described how in relation to non ID offenders, this group were more “worthy of help” which linked to their feelings of pride in relation to being involved in this work.

Second, “view of the future” has been identified as a specific responsivity factor for this group. Some participants reported feeling positive about the future, a finding which was also reported by Wakeling, Webster and Mann (2005). But others described this fear of the future. Treatment participants seemed to recognise that in order to live a life without reoffending, they would require further support, and were concerned that this might not be available. The research indicates that if released sexual offenders are provided with stable housing, able to access pro social networks, able to create intimate relationships and find employment, they are less likely to reoffend (Hanson and Harris, 2000; Hanson and Morton - Bourgon, 2005; Hepburn and Griffin, 2004; Willis and Grace, 2008, 2009). It is somewhat surprising that this factor has not been previously reported in the literature. Twelve of the sample had completed treatment within 4 months or less of the focus group date, seven of the sample had completed treatment 9 -12 months previously. It is hypothesised that fear of the future was expressed by those who had been out of treatment for longer. The fear may be a consequence of not being a part of a group currently, or anxiety about a lack of support as they progress towards release. Indeed, some group members did talk about wanting to continue to be part of a group even though they knew that this was not possible. The participants talked about a fear of being alone and alluded to being afraid that people would not be able to help them with other aspects of their lives that they acknowledged they needed support with (e.g. accommodation etc). Any feelings of worry or fear are likely to impede treatment success as they are likely to impact on feelings of inadequacy and self resilience. This fear for the future has not been reported in the literature although researchers do outline how wraparound support is needed for IDSOs (e.g. Haaven *et al.*, 1990). Further research is needed to explore this in more detail. Therapists also described concerns about the future for this group. They noted the lack of opportunities available and worried that without support many would struggle to engage

successfully in society and manage their lives without reoffending. The management of fear is therefore a responsivity factor which warrants further attention within BNM.

A by product of this research has been the knowledge gleaned about other treatment approaches for non ID offenders, which participants have attended and/ or therapists have worked on. In describing treatment experiences, both participants and therapists often compared their experience on BNM to that on other treatment approaches. In doing so, a specific responsivity factor, shame, was identified for these other treatment approaches. Shame has been linked to personal distress, denial, motivation and locus of control. This suggests that the experience of shame is likely to be an important factor in predicting an offender's ability to engage effectively in treatment (Marshall *et al.*, 2009). As such, shame has been identified as a specific responsivity factor for IDSOs when they attend treatment approaches which have not been specifically designed to meet their needs. Although the identification of this factor is wider than the remit of this thesis, given its likely importance for the treatment of this client group, it has been reported.

Another specific responsivity factor identified by therapists relates to their work with non IDSOs. They described their suspiciousness of the non ID client group. They felt that they were more likely to malingering or "blag" their way in treatment. This suspiciousness of sexual offenders (without intellectual disabilities) appears to link to the previous finding that BNM therapists adopt a different set of attitudes, or schemata, when working with ID individuals. This finding warrants further investigation.

10.3 Summary of the research findings

The research question in this thesis is can the RNR model be successfully applied to the treatment of IDSOs. In relation to risk, this research confirms that the BNM approach leads to change in the desired direction for all men (irrespective of their risk classification) on all of the BNM

assessment measures (except “child abuse supportive beliefs,” SOOT). In relation to need, this research has provided eight psychometric assessments to assess the criminogenic needs of IDSOs. The psychometric properties of each assessment were tested, and their use to assess the needs of IDSOs is generally supported. In relation to responsivity, two studies were undertaken. Firstly, a pre post research design confirms that the BNM approach led to treatment change in the desired direction for all participants, irrespective of their IQ level, age or offence type on all measures (except the “child abuse supportive” beliefs component of the SOOT and the “sexual preoccupation” component of the MPI). Second, this research provided a qualitative examination of the BMN treatment experience for participants and therapists to determine how well the responsivity factors identified in the literature had been accommodated for within the BNM design. This research confirms that the responsivity factors had generally been accommodated for. It also identified some factors which are new to the literature base. This study is the first to report positive treatment experiences for therapists working with ID individuals. Moreover, this research has provided new insights into the responsivity principle in relation to the treatment of IDSOs (and also to treatment with other offender groups) which have not previously been reported. However, these results do not provide conclusive evidence about the success of the RNR model with this group. A more rigorous scientific investigation (e.g. RCT trial or comparison group study which incorporated recidivism data) would be required to determine this. Nevertheless, the research has provided a number of important contributions to the field.

10.4 Contribution to the field

Firstly, a battery of psychometrically useful assessments is now available to enable the assessment of criminogenic needs for intellectually disabled sex offenders. The applicability of the research findings is also of relevance to those working with ID offenders who have not committed a sexual offence. Some of the adapted assessments measure general criminogenic needs which play

a role in other types of offending. The adapted self esteem scale, the adapted impulsivity scale, the adapted ruminations scale, and the adapted relationship style questionnaire, are likely to be applicable to a wider population of ID individuals and it is recommended that the use of these measures is considered more widely for ID offenders in prison.

Second, this investigation into the effectiveness of the BNM approach suggests that it may be useful in addressing the criminogenic needs of IDSOs. Changes between pre and post treatment suggest that IDSOs have changed in important ways across these two time periods. It appears that this is a result of BNM treatment. However, as has been previously described (chapter 1), limitations in relation to the overall treatment design, and those specific to the study itself, mean that these results provide no conclusive evidence that BNM treatment is effective in reducing recidivism. It is argued that even with the most scientifically controlled research design, a treatment effect in terms of reduced recidivism is difficult to prove with this client group due to the low base rate of offending and the length of follow up time needed. Nevertheless, it is recommended that future research using a matched comparison group control design is undertaken if this possibility arises within HM Prison and Probation Service. Should routine ID screening of all offenders become mandatory, this is will easier to achieve.

Lastly, given that there has been little/ no previous research undertaken on the treatment experience of participants and therapists working with this client group, the process evaluation provides new insights for the literature. Furthermore, greater clarity in terms of defining the factors which are important in treatment responsivity with IDSOs has been achieved. A wider definition of the general responsivity principle, to include factors pertaining to treatment approach, therapist characteristics, group environment and treatment context has been tested. This has included factors which pertain to both participants and therapists. Although previous researchers have identified the importance of the therapist's role in treatment, to date responsivity factors

have always been reported through the eyes of the participants. In this research the factors affecting the therapists themselves are also described. Together, this research has provided a depth to our understanding of the important responsivity factors in the treatment of IDSOs.

The research has also identified factors that to date have not been previously described in the literature. In relation to the treatment approach, coming to terms with the fact that Old Me will always be a part of their lives, and that others will always view them as a “bundle of risks” was identified as a new responsivity factor for treatment participants. New insights into the role of the therapist in IDSO treatment has helped provide clarity to the therapist characteristics responsivity factor. More specifically, it is clear that therapists involved in the treatment of IDSOs behave and think differently about their role (in comparison to their role as a therapist in non ID treatment). Their attitudes towards the IDSOs tend to be more accepting and they are less likely to be suspicious, they also describe “befriending” behaviours which they do not have in their treatment with non IDSOs. In relation to treatment context, although organisational context and climate factors have previously been discussed, it is clear that there is a need to heighten awareness about sexual offending amongst non treatment staff who work with IDSOs. In relation to specific responsivity, two new factors relating to ID characteristics and fear for the future were identified. These factors are important to treatment responsivity and success and as such, it is important that the BNM approach is adapted to accommodate these factors.

10.5 Research recommendations to improve understanding about the risk, need and responsivity principles

The pre – post treatment research design adopted in this study is unable to provide conclusive information about treatment effect. In an ideal world a randomized treatment design or a research study which involved matched comparison groups would be implemented. However, as outlined

earlier in chapter 1, there are various practical reasons why these approaches are very hard to achieve with this client group in correctional settings. However, if opportunities arose to undertake a research design which can involve a comparison group, this must be prioritised.

If however, this is not possible, it is recommended that a comparison of “treated” and “untreated” offenders with recidivism rates is calculated. Replicating the design adopted by Beech *et al.*, (2001) or Marques *et al.*, (2005) with non ID sexual offenders might help to provide greater knowledge about the applicability of risk and need in IDSOs. These studies provide support for the link between psychometric scores and reconviction outcome and give some hope to the application of the results of this study to preventing future reoffending. However, there is currently, no literature to support a link between psychometric scores and reconviction outcome with IDSOs and this is an important area for future research.

Although this research has reported on the internal consistency and construct validity of the eight BNM measures, it would be useful to test concurrent validity by comparing the BNM measures with other established measures. Realistically, this will be hard to establish as there are so few assessments measuring criminogenic needs which have been specifically developed for this client group.

In the sexual interests domain, the Multiphasic Sex Inventory (MSI: Nichols and Molinder, 1984) is a 300 item measure designed to assess the psychosexual characteristics of sexual offenders. Despite its length, it has been used to measure treatment change in a sample of low functioning sexual offenders by Craig, Stringer and Moss (2006). They found treatment generated significant changes on variables such as sexual knowledge and honesty about their sexual interests, but are cautious about the interpretation of these results because the measure was not standardised on ID populations. Given the established properties of the MSI, the importance of having a useful

assessment measure for this important area of criminogenic need, and the fact that the MSI has been reported as potentially useful with IDSOs, further research is perhaps warranted. Yet, given the number of items in this measure, there are grave concerns about the practical value of this tool. Further, Farrren and Barnett (2011) recently investigated the concurrent validity of the MPI subscales with the relevant MSI subscales in a sample of 1,013 sexual offenders (non ID). They found that all four subscales of the MPI significantly correlated with the relevant MSI subscales. The relationships ranged from moderate to large which the authors concluded demonstrated that the MPI had good construct validity. Although this study was conducted on non ID sexual offenders, given that the MPI appears to be as valid as the MSI, was developed specifically for IDSOs and has fewer items, the practical applicability and relevance for IDSOs is clear.

The one area where some considerable work has been undertaken in developing an assessment for this client group is offence related attitudes and distorted thinking. The “Questionnaire on Attitudes Consistent with Sexual Offending” (QACSO; Broxholme and Lindsay, 2003; Lindsay, Carson and Whitefield, 2000) attempts to assess distorted cognitions relating to sexual offending. It is described in chapter 4.3 of this thesis. The QACSO was considered for inclusion into the BNM assessment battery as an alternative to the SOOT which also assesses offence related attitudes. A number of experienced treatment staff were asked which assessment they felt was best suited to the needs of our client group. The QACSO is longer and is written in a more complicated style. The SOOT is simpler and makes use of interactive methods which are consistent with the BNM treatment approach. As such it was felt that the SOOT was a more appropriate assessment measure than the QACSO and it was included in the adapted assessment battery.

The aim of the assessment process is to determine the criminogenic needs of IDSOs so that a) treatment can be tailored to meet their needs, and b) we can determine whether treatment has

been effective in reducing the levels of need. This information is used as part of the risk assessment process, the results of which have significant consequences for each treatment participant. Decisions about progression through the system and eventual release are made, in part, on the basis of the risk assessment process. It is therefore, fundamental that the information gleaned from the assessment process is reliable and valid. Moreover, the assessment process must tap into all of the criminogenic needs of this group. The BNM assessments tested in this study tap into a number of different criminogenic needs; the MPI measures sexual interests (sexual preoccupation, preference for sex with children, preference for sex to include violence and other offence related sexual interests), the SOOT measures child abuse supportive beliefs and the belief that women can not be trusted. The criminogenic needs which form the relationships domain (feeling inadequate, feeling more comfortable with children than adults, suspicious, angry and vengeful towards others and not having an intimate relationship) are measured via the adapted self esteem questionnaire, the Openness to women and men scales and the adapted relationship style questionnaire. In the area of self management, impulsivity is measured by the adapted impulsivity scale. There are however, a few criminogenic needs which are, as yet, not assessed via the BNM assessment battery. In the attitudes supportive of offending area, beliefs about sexual entitlement are not measured. In the self management area, not knowing how to solve life's problems and out of control emotions or urges are also not currently assessed. There are no existing available measures to assess these areas. It is strongly recommended that new assessments are adapted or developed to assess these criminogenic needs. The properties of these new assessments must be determined to ensure that they are reliable and valid for use with this group.

As described in chapter 2, the criminogenic needs on which the BNM approach is based, have been established from the wider sex offender literature base. There is no specific literature pertaining to IDSO criminogenic needs. As such, it is important that this is the subject of further

research attention. Recently, Camilleri and Quinsey (2011) have suggested that IDSOs may have additional criminogenic needs which to date have not been identified. They suggest that the unique characteristics of ID, e.g. slower information processing, concrete thinking, language and communication problems and so forth, may be criminogenic. This has not yet been tested and warrants further attention.

BNM is only available to IDSOs who score medium, high or very high on RM2000/s. Lower risk men are considered unlikely to warrant the level of treatment that is offered within BNM. Further, studies on sexual offenders suggest that over treatment can lead to increased risk of recidivism. There is however, no research based on ID individuals and it is therefore important that this work is undertaken.

It has been suggested that some of the results achieved in this study may be a result of a) a false belief of the amount of change that has been achieved (i.e. self deception) or b) a desire to deceive others by presenting as changed following treatment (deceiving others). As such, in recent reviews, researchers have suggested alternative methods for the assessment and evaluation of treatment approaches.

Barnett, Wakeling, Mandeville- Norton, and Rakestrow (2011) examined the relationship between psychometric test scores and sexual and/ or violent reconviction in a sample of 3,402 convicted non ID sexual offenders (who had attended a probation run sex offender treatment programme in England and Wales) and found that post treatment scores on psychometrics generally were less discriminative and predictive of reconviction than pre treatment scores. Although there is no clear reason for this, Barnett *et al.*, propose that this is because pre treatment scores may be a “purer” measure of dysfunction than post treatment scores. That is, pre treatment scores are less likely to have been impacted by socially desirable responding. The authors

concluded that programme evaluators should place less emphasis on post treatment scores on psychometric measures of criminogenic needs as a way of establishing the efficacy of treatment programmes. It could be argued therefore that there is little need to undertake post treatment assessment. Given that any assessment is costly and time consuming, were there no need for post treatment assessment, this could amount to considerable savings. The argument used by Barnett *et al.*, should mean that the internal consistency of all of the components/ measures within the BNM battery should be affected by socially desirable responding, yet, this does not appear to have been the case. Indeed, some of the results of this research indicate that the IDSOs have responded openly and honestly. For example, the fact that the “problematic sexual interest in children component” of the MPI was more likely to be endorsed by those who had offended against children than those who had offended against adults at both the pre and post treatment stages, suggests that this is a valid response pattern. As such, it is recommended that further research is undertaken to explore this.

Although socially desirable responding does appear previously to have impacted treatment outcome with IDSOs (i.e. floor effects have been reported in Keeling *et al.*, 2006; Newton *et al.*, 2011), this has only recently been explicitly examined. Langdon, Clare and Murphy (2011) have recently reported on the development of the self and other deception questionnaires which has been specifically designed for use with ID individuals. They tested these questionnaires on a group of 32 ID men, and a group of 28 non ID men. They found that the ID men scored significantly higher on both the self and other deception questionnaire than the non ID group. As such, it seems that socially desirable responding may be an important issue in this client group.

Indirect measures of assessment, which are less susceptible to manipulation, have recently been developed and applied to sexual offending. With indirect measures, participants are less

aware of the nature of the measure or the measurement principle. These assessments are known as tests of implicit association (IAT). The IAT (Greenwald *et al.*, 1998) was first used in the field of social psychology to examine socially sensitive topics, such as racism. The IAT assesses the strength of cognitive associations by comparing reaction times to different pairings of concepts. The IAT does not require direct questioning of participants and reduces the impact of conscious intention or deliberative processes on responses (Nosek, Greenwald, and Banaji, 2007). A range of forensic indirect measures have been developed for non ID offenders to tap into various domains of individual differences (Snowden and Gray, 2010). Much of the work in relation to sexual offenders, has focused on deviant sexual interests in children (for a recent overview see Snowden, Craig, and Gray, 2011). This is a new area of research which provides a possible solution to the problem of socially desirable responding on self report measures. To date the research has exclusively focused on non ID sexual offenders and it is recommended that this work is extended to IDSOs.

Finally, in any programme evaluation, it is important to consider those that did, and those that did not, complete treatment. Although the relationship between non completion and reoffending has been established with mainstream sexual offenders, this has not been the subject of investigation with IDSOs, and as such it is recommended that this work is undertaken.

In this research, the experiences of the therapists in treatment have been combined with those of the participants to develop a broader understanding about responsivity. It is assumed that any factors interfering with therapist treatment experience will impact on their delivery of the treatment sessions. This assumption warrants further investigation. It is important to investigate further the extent to which negative treatment experiences for therapists affect their facilitation of a treatment group.

It is recommended that further research is undertaken to establish in greater detail the attitudinal shift that therapists make when working with IDSOs. This change in attitude and behaviour is likely to have a positive impact on therapeutic alliance and treatment success. These are important considerations for all treatment and as such, it would be helpful if these changes could be adopted by non ID therapists too.

Therapists on the BNM talked about feelings of autonomy associated with a freedom to personalise treatment approaches for IDSO individuals as a positive of BNM experience and highlighted that this is not an approach which they adopt on other non ID treatment approaches. It is important that further investigation is undertaken to find out more about this. Why do therapists feel unable to personalise treatment for non ID offenders? What enables this on BNM? Given the importance of personalising treatment for individuals (as is characterised by the responsivity principle), this work is needed to inform non ID treatment delivery.

One finding that was new to the responsivity literature related to the view of self as a *"bundle of risks."* This was connected to the negative experience of disclosing offence details and the associated fact of having to accept that Old Me would always be a part of their lives. Another new factor was fear for the future. Both of these responsivity factors appear to stem from a negative view of self. Neither result would be expected within a strengths based treatment approach. Moreover, treatment is unlikely to be successful if it leads to negative self image or poor self esteem. Given that the outcome evaluation suggested that in general, participants' scores on the self esteem questionnaire improved as a result of treatment, it does not seem that this negative view of self is common to all participants. Nevertheless, these two new responsivity factors warrant further research attention.

It is important to comment on various factors relating to research methodology which provide further opportunities for research. Firstly, it is recommended that this research is repeated by an independent researcher. The researcher is the national lead for this approach and as such, focus group participants and therapists may have been influenced by this. Second, factors pertaining to the treatment experience were assumed to have been successfully accommodated for if there was no mention of them. This may be an unreliable assumption and it is recommended that further investigation is undertaken to determine this.

Finally, the research has provided new insights into the nature of responsivity in the treatment of IDSOs. The decision to examine the responsivity principle from both the participant and the therapist's view point is therefore warranted and it is recommended that this approach is adopted in any further research which examines treatment responsivity.

10.6 Implications for practice

There are a number of recommendations from this research that will help to improve adherence to the RNR principles. These have been outlined below.

Some modification to some of the BNM measures is recommended. It is suggested that item 3 is removed from the adapted impulsivity scale, which will improve the reliability of the scale. A 12 item scale provides a better measure of impulsivity. Similarly, it is recommended that one item is removed from the adapted ruminations scale (item 15). A 10 item scale provides a better measure of ruminations. Five items should be deleted from the adapted relationship style questionnaire to improve reliability (items 6, 12, 15, 10 and 29). On the openness to women scale, reliability is improved when items 8 and 9 are removed. Similarly, the removal of items 8 and 3 in the openness to men scale also improves reliability. The reliability of the SOOT would be improved by removing items 9 and 17. In relation to the MPI, firstly, it is imperative that the measure is reprinted. The

two items which have been printed out of the main body of the text must be included within the scale. The psychometric properties of the full scale must be examined so that more conclusive results about the measures usefulness and applicability to this client group can be made.

There were a number of recommendations from the process evaluation discussions which would improve the responsiveness of the BNM approach. For therapists, both the literature and the practitioners themselves described the importance of supervision and a strong treatment team. Within supervision: it is important that the following issues are addressed; coping with group member specific stressors, advising on boundary dilemmas (advising on managing the needs of group members), intrusive thoughts and ruminations, and any co-working issues relating to poor therapist relationships. Further, it is recommended that supervisee training needs are developed in supervision, especially in relation to treatment concepts which are not fully understood. It would be beneficial for treatment supervisors to encourage supervisees to focus on the positive aspects of delivery to encourage a balanced reflection on the treatment experience. Focusing on personalising treatment approaches, tailoring expectations, and encouraging therapist autonomy through the development of creative multi modal treatment techniques, will enable understanding and promote strong group cohesion. Providing opportunities for therapists to reflect on their ability to “make a difference,” and encourage feelings of pride in their work will also help to promote the positive aspects of treatment delivery.

It appeared that some staff within this research were showing symptoms of secondary traumatisation (intrusive thoughts and rumination), and it is recommended that plans for managing the negative consequences of this are put into place. A process for identifying symptoms and providing access to support/ counselling is needed. Further, support for newly trained staff is

recommended to enable the process of adjustment which has been described. Support during this time would help therapists to adjust to the differing needs of this client group.

The selection of group members into BNM treatment needs careful planning and attention. Group composition is an important consideration in treatment. Men with behavioural problems and issues of trust appear to be particularly problematic and attention needs to be given to assessing these variables prior to treatment starting, and assisting therapists in managing the impact of men with these particular features during treatment. Furthermore, it is important that mental health is closely monitored throughout treatment. This factor was perceived by both participants and therapists to contribute to negative experiences.

It is recommended that peer led support groups are encouraged so that participants have opportunities to work together to maintain and strengthen treatment gains. Offenders who have mentoring or supporting roles on the landings should also receive training so that they can provide support to men who are having negative experiences in treatment. Efforts to minimise feelings of anxiety pre treatment are encouraged, and it is recommended that treatment graduates are invited to pre treatment sessions to help group members hear “the truth” about treatment.

In terms of treatment design, most treatment concepts, methods and techniques were experienced as positive and useful by both participants and therapists. It is important however, that information pertaining to risk is clarified and presented in more user friendly ways. The approach to imparting information about risk has been rewritten as a result of this research. A picture based card game has been developed to enable and promote discussion about each risk factor. The card game is undertaken in a one to one setting with a treatment therapist prior to treatment starting. This pre treatment session acts as a primer to the treatment itself where this work is continued within the group setting. A second individual session at the mid treatment stage

is used to check participant understanding of risk. This mixture of individual and group work has helped participants clarify their understanding about the risk factors which are pertinent to them.

Participant's high levels of needs and resultant chaotic lifestyle reported by the therapists appear often to lead to feelings of stress and pressure for both therapists and treatment participants. It is recommended that treatment approaches are developed for participants to help them with their problem solving skills. Cognitive skills programmes are a common place treatment option for non ID sexual offenders, but to date, no treatment options for ID offenders exist. As Lindsay, Hamilton, Moulton, Scott, Doyle and McMurran (2011) point out "by definition, the population of people with ID lack cognitive skills in comparison to the general population and it follows, therefore, that offenders with ID will also lack cognitive skills." The authors note that cognitive skills deficits are not primary features of offending but suggest that they may be contributory factors. Clearly, results from this study suggest that a lack of cognitive skills means that the many problems/ needs the men present are not only problematic for them, they also lead to negative feelings in therapists who struggle to identify which problems are or are not relevant to "treatment." It is therefore recommended that an ID cognitive skills approach is developed to meet the needs of this client group.

It is important that activities to provide a scaffolding of support for treatment work are developed. It is important that the organisation as a whole accepts and promotes the value of rehabilitation. This must be communicated to staff to enable the provision of necessary support and delivery services. The climate of an organisation is clearly relevant to treatment success. This responsivity factor was described by both therapists and participants and is outlined extensively in the literature (see chapter 4). In particular, it is important that training is provided to others who work with this client group to promote understanding. This should include staff, for example wing

staff, offender supervisors and managers, custodial managers, and hostel staff. The nature of the training should focus on risk and protective factors associated with sexual offending, supporting IDSOs in treatment and recognising offence paralleling behaviours.

It is recommended that within treatment strategies to manage the specific responsivity factor relating to fear of the future are established. Wider opportunities for treatment participants to develop their skills beyond treatment are needed. Support that extends beyond the limits of a programme is required with opportunities to practice and develop skills so that real gains in social experiences can be made. It is recommended that various supporting agencies are invited to work collaboratively with treatment providers so that links can be established and developed locally to meet these needs.

It is also recommended that further investigation into the attitudes of therapists in treatment is explored. When working on the BNM, therapists reported a shift in attitude. They described a different approach based on a BNM set of schemata. They also reported that they behaved differently, describing a need to “befriend” IDSOs. In contrast, in their work with non ID offenders they are more suspicious about men’s motives and suggest that they are more likely to “blag” it and malingering in treatment.

Finally, it is recommended that more treatment approaches are specifically adapted to meet the needs of this client group. A responsivity factor for treatment which has not been previously identified in the literature relates to the shame experienced by ID men undertaking treatment approaches which had not been accommodated to meet their needs. Feelings of shame, discomfort, and embarrassment are not conducive to learning and change. Indeed they are likely to lead to treatment failure. It is inappropriate for men with ID to attend treatment which has not been specifically tailored to meet their needs. This is an important new finding for the literature.

10.7 Conclusion

This research is the first to apply the RNR model to the treatment of IDSOs. It has outlined how the BNM treatment programme was developed and evaluated in line with the principles of Risk, Need, and Responsivity. Three research studies, including an outcome and process evaluation, were undertaken to determine whether the RNR model can be successfully applied to this client group. In summary, results suggest that the BNM treatment approach successfully addresses the criminogenic needs of IDSOs (irrespective of their risk level, IQ, age or offence type), and further, that it is a largely positive experience for both participants and treatment therapists. As such, it can be concluded that the BNM programme is a useful treatment approach for this client group and moreover, that the RNR treatment model can be usefully applied to IDSOs. The research has provided a number of other new insights and contributions. Notably, a battery of eight psychometric assessments to assess the criminogenic needs of IDSOs is now available. Further, this research has provided a new level of understanding about responsivity by including the treatment experiences of both the participants and the therapists. Indeed this research, is the first to report positive treatment experiences for therapists working with ID individuals. Further, it has provided new insights into the factors which are relevant to responsivity in the treatment of IDSOs (and also to treatment with other offender groups) which have not previously been reported. Recommendations for practice and suggestions for future research have been identified.

This research aimed to advance our understanding of the assessment and treatment of IDSOs and as such, it has made a contribution both scientifically and clinically. As such, it not only fulfils the requirements of the Psych D qualification, but it also serves to provide evidence to support the continued funding of this important work. Given the current financial climate, it is imperative that

an evidence basis for any treatment approach is available for scrutiny by senior managers who hold the financial purse strings. This research has provided an evidence base which has enabled the expansion of the programme in terms of availability in custody and in the community. It is now available in 15 custody sites and 3 community trusts (and it is expanding year on year). It has also led to the development of further accredited treatment approaches for IDSOs, which include a new programme for lower risk IDSOs, a maintenance approach for BNM graduates, and a programme which focuses exclusively on sexual preoccupation and other offence related sexual interest. Further, this research has helped to consolidate the need for the development of other assessment and treatment approaches for ID offenders, and this work is now underway. Finally, the treatment approaches and techniques used within the BNM approach have been adopted more widely in treatment approaches for non ID sexual offenders. The recognised benefits of the BNM approach in terms of attending to responsivity factors has led in part to changes in the general approach for non ID sexual offenders.

Ultimately, my aim was that this research would enable a better life for IDSOs, and thereby prevent any further victims. I hope that I have achieved this.

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